. S. No. 2
OM—8-43
v. 5-17-39
I X37823

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 6 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19953

Registration District No. 373 Primary Registration District No. 6268 Registrar's No. 37

1. PLACE OF DEATH:

(a) County Webster
(b) City or town Niangua
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Schlicht-Hospital O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 weeks. (Specify whether
In this community 1 yr.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Webster 1/2
(c) City or town Rural O
(If outside city or town limits, write "RURAL")
(d) Street No. West of Fordland O
(If rural, give location) O
(e) Citizen of foreign country? No (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Johnie F. Reed
3. (b) If veteran, name war —
3. (c) Social Security No.
4. Sex M.D
5. Color or race W.
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife X
6. (c) Age of husband or wife if alive X years
7. Birth date of deceased May (Month) 21 (Day) 1904 (Year)

8. AGE:	Years	Months	Days	If less than one day
	42	11	26	hr. min.

9. Birthplace (City, town, or county) Kansas (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name H. S. Reed
13. Birthplace (City, town, or county) Mo O (State or foreign country)
MOTHER
14. Maiden name Susan Seaton
15. Birthplace (City, town, or county) Mo O (State or foreign country)
16. (a) Informant Mrs Blanch Maynard
(b) Address 339 W Pine St Springfield
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 20 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Richland Cem
18. (a) Signature of funeral director Kelley-Ferrell-Bergman
(b) Address Fordland Mo
19. (a) 5/19-47 (Date received local registrar) (b) J. Francis (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 17 day May year 1947 hour 5 minute 30 M.
21. I hereby certify that I attended the deceased from May 1 1947 to May 17 1947 that I last saw him alive on May 17 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Gastric Ulcer	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

1178

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury O
23. Signature W. F. Schlicht (M. D. or other)
Address Niangua Mo Date signed May 19/47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 647-620
Date Filed JUN 4 1947

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed K. K. Kelley

Licensed Embalmer No. 9334

P. O. Address Fordland Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.