

National Office of Vital Statistics

State File No. \_\_\_\_\_

Registration District No. 170

Primary Registration District No. 3033

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town Lebanon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Wallace Memorial  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: 24 hrs  
In this community entire life  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede  
(c) City or town Lebanon  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Vada Reid

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: May 26 1932  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
15 4 26 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Laclede Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation school girl

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name John W. Reid  
13. Birthplace Laclede Co. Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Ellen Farris  
15. Birthplace Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant John W. Reid  
(b) Address Lebanon Mo.  
17. (a) Burial (b) Date thereof 10-24-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Cross Roads

18. (a) Signature of funeral director W. E. Holman  
(b) Address Lebanon Mo.  
Nov 1, 1947

19. (a) \_\_\_\_\_ (b) Org. Frankel  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22 year 1947 hour 8 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Oct. 21 1947, to Oct. 22 1947  
that I last saw her alive on Oct. 22 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death diffuse peritonitis  
Duration 2 days

Due to Generalized pelvic infection & ruptured appendix  
Due to \_\_\_\_\_

Other conditions gonorrhea  
(Include pregnancy within 3 months of death)

Major findings: entire abdomen full of pus & adhesions. Left tube 0.5 cm. ovarian abscess.  
Of operations \_\_\_\_\_

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

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 \_\_\_\_\_

23. Signature Her Carrington (M. D. or other) M.D.  
Address Lebanon, Mo. Date signed 10/21/47

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

Received 11/5/47

Laclede County Health Unit

Case No. 11-47-188

Date 11/5/47

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.