

No. 2  
-1/47  
17-39

FILED NOV 24 1947  
Registration District No. **1987**

Primary Registration District No. **3028**

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

1. PLACE OF DEATH:

(a) County **Jasper**

(b) City or town **Carthage**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**McCune-Brooks Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2 days**  
(Specify whether years, months or days)

In this community **6 months**  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper**

(c) City or town **Carthage**  
(If outside city or town limits, write "RURAL")

(d) Street No. **918 Olive St.**  
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME **MOSE REED**

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

4. Sex **male** ( ) race **white**

5. Color or divorced **married**

6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Margaret Ann Reed**

6. (c) Age of husband or wife if alive **71** years

7. Birth date of deceased **March 22 1858**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>89</b>	<b>7</b>	<b>24</b>	..... hr. .... min.

9. Birthplace **unknown Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **retired farmer**

11. Industry or business.....

12. Name **unknown**

13. Birthplace **unknown**  
(City, town, or county) (State or foreign country)

14. Maiden name **unknown**

15. Birthplace **unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Clyde Reed**

(b) Address **918 Olive, Carthage, Mo.**

17. (a) **removal** (b) Date thereof **Nov 6, 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rogers, Arkansas**

18. (a) Signature of funeral director **Knell Mortuary**

(b) Address **Carthage, Mo.**

19. (a) **11-6-1947** (b) **L. B. Clinton, md**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **6**  
year **1947** hour **8:20** minute..... A.M.

21. I hereby certify that I attended the deceased from **Nov. 3** 19**47**, to **Nov. 6** 19**47**  
that I last saw him alive on **Nov. 6** 19**47**  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
**Acute congestive heart failure with arteriosclerotic heart disease.**

Due to **Intertubercular fracture of left hip**

Due to.....

Other conditions **Basal cell carcinoma of face**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....

Duration

**3 1/2 days**

**4 days**

PHYSICIAN  
NEELEY  
INFORMED  
REQUESTED

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 **Charles H. Schell** (M. D. or other) **md**  
Address **347 S. Main, Carthage,** Date signed **Nov 6, 1947**



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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..... *Frank W. Knell Jr*  
Licensed Embalmer No..... *4440*  
P. O. Address..... *Carthage*

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.

Registration District No. 155

Primary Registration District No. 3028

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Mose Reed

3. (b) If veteran, name war M 3. (c) Social Security No. W

4. Sex M 5. Color W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Mose 6. (c) Age of husband or wife if alive 12

7. Birth date of deceased March 12 1935  
(Month) (Day) (Year)

8. AGE: Years 89 Months 7 Days 22 (Less than one day) hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov year 1947 day 21 hour 10 minute 6 M.

21. I hereby certify that I attended the deceased from 11/21/47 to 11/21/47 that I last saw him alive on 11/21/47 and that death occurred on the date and hour stated above.

Duration  
Due to  
Due to  
Other conditions (Include pregnancy within 3 months of death) 166 9 168 10

Major findings: Of operations  
Of autopsy

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

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) accident  
(b) Date of occurrence Nov. 21, 1947  
(c) Where did injury occur? Carthage Jasper Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
home - fall off front porch  
(Specify type of place) (e) Means of injury fall to ground  
While at work?  
23. Signature Charles H. Isbell (M. D. or other) M.D.  
Address Carthage, Mo. Date signed 12/2/47

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

SUPPLEMENTARY

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ENTRE

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