S. No. 2
8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 2 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8029

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 93

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp. # 1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 1-14-48 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon 61
(c) City or town College Mound 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Douglas Reed
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept (Month) 1 (Day) 1863 (Year)

8. AGE: Years 84 Months 6 Days 19 If less than one day hr. min.

9. Birthplace Macon Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation farmer
11. Industry or business farm
FATHER
12. Name Wm Reed
13. Birthplace UNKOWN (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name UNKOWN
15. Birthplace UNKOWN (City, town, or county) 9 (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Fulton Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-20-1948 (Month) (Day) (Year)
(c) Place: burial or cremation Union - Macon Co
18. (a) Signature of funeral director Albert Skinner
(b) Address Macon - Mo
19. (a) 3-20-1948 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 20 year 1948 hour 4 45 minute a M.
21. I hereby certify that I attended the deceased from 3/18/48, 19 to 3/20/48, 19; that I last saw him alive on 3/19/48, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chr myocarditis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) gen arteriosclerosis	

Major findings:
Of operations 93 D
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)
(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 0.
23. Signature J C Caldwell (M. D. or other) Mo
Address Fulton Mo Date signed 3/20/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed MAR 31 1948

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 Thos L. Batt, Registered Apprentice No. 37 working under my personal supervision.

Signed Howard F. Myers

Licensed Embalmer No. 4494

P. O. Address Macon - 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.

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 93

1. PLACE OF DEATH:

(a) County Callaway Fulton

(b) City or town (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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Douglas Reed

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, ~~married~~, divorced W

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days If less than one day hr. min.

9. Birthplace (City, town, or county) No (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH 20 Day year 1948 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

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.

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 (M. D. or other)

Address Date signed

SUPPLEMENTARY

1948
5-8024