S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 1 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15500

Registration District No. 42 — Primary Registration District No. 1000 — Registrar's No. 594

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Mo. Meth. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks (Specify whether
In this community 14 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1015½ Frederick Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Robert R. Reed
3. (b) If veteran, name war No
3. (c) Social Security No. 491-09-0593

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Laura Reed
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased September (Month) 20 (Day) 1886 (Year)

8. AGE: Years 61 Months 8 Days 5 If less than one day ..... hr. ..... min.

9. Birthplace Springdale (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation School Principal
11. Industry or business Gards University
FATHER
12. Name Lee Reed
13. Birthplace Unknown (City, town, or county) Arkansas (State or foreign country)
MOTHER
14. Maiden name Dosia Owenby
15. Birthplace Unknown (City, town, or county) Arkansas (State or foreign country)
16. (a) Informant Mrs. Laura Reed
(b) Address St. Joseph, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/27/48 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park
18. (a) Signature of funeral director Heaton-Bowman
(b) Address St. Joseph, Mo.
19. (a) 5-28-48 (Date received local registrar) (b) E. C. Jenkins (Registrar's signature) 3 x 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25 year 1948 hour 12 minute 01 AM.

21. I hereby certify that I attended the deceased from 5/5/48, 19..., to 5/25, 1948; that I last saw him alive on 5/24, 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Peri rectal abscess	2 wks.
Diabetes mellitus	Mucron 3 wks.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 W. M. Teathaber M.D. (M. D. or other)
Address 911 Kirkpatrick Bldg. Date signed 5/25/48.
St Joseph, Mo.

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th, St. Joseph, 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.