

FILED FEB 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 317

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 118

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buch.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3302½ Mitchell, Ave. /		d. STREET ADDRESS (If rural, give location) 3302½ Mitchell, Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Emma	b. (Middle) S.	c. (Last) Reed	4. DATE OF DEATH (Month) (Day) (Year) Jan. 26, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Oct. 1, 1861	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Clarinda, Iowa /	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME S. F. Pendergroff	13b. MOTHER'S MAIDEN NAME Unk.	14. NAME OF HUSBAND OR WIFE W. D. Reed
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME Glen C. McMichael-St. Joseph, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial failure		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 5 yrs. 5 yrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) chronic myocarditis DUE TO (c) senility		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4220	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from July 1, 1947, to Jan. 26, 1949, that I last saw the deceased alive on Jan. 25, 1949, and that death occurred at 6 a.m., from the causes and on the date stated above.

23a. SIGNATURE W. Jastiches (Degree or title)	23b. ADDRESS St. Joseph, Mo. 711 Kirkpatrick	23c. DATE SIGNED 1/27/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Jan. 27-49	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Clarinda, Iowa
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DATE REC'D BY LOCAL REG. Jan. 31, 1949	REGISTRAR'S SIGNATURE B. L. Jenkins	3820	25. FUNERAL DIRECTOR'S SIGNATURE Stamey Funeral Home	ADDRESS Stamey Funeral Home - St. Joseph, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed.....

Charles M. Johnson

Signed.....

Student Embalmer

Licensed Embalmer No. 4487

P. O. Address St. Joseph

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.