

FILED DEC 1 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38285**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **278** PRIMARY REG. DIST. NO. **3054** Registrar's No. **97**

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

1. PLACE OF DEATH a. COUNTY <b>Pike</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Pike</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Louisiana</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Louisiana</b>	
c. LENGTH OF STAY (In this place) <b>Lifetime</b>		d. STREET ADDRESS (If rural, give location) <b>500 Virginia St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>500 Virginia St.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Emma</b> b. (Middle) <b>Alice</b> c. (Last) <b>Reed</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 13, 1949</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED; WIDOWED, DIVORCED (Specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>2/28/1863</b>		9. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Louisiana, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					

13a. FATHER'S NAME <b>Charles Ragsdale</b>		13b. MOTHER'S MAIDEN NAME <b>Lavina Waters</b>		14. NAME OF HUSBAND OR WIFE <b>Benjamin Reed (Deceased)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Miss Margaret Reed, Louisiana, Mo.</b> ADDRESS <b>-----</b>	

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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pneumonia Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Paralyzed Arteriosclerosis</b>		DUE TO (c) <b>-----</b>		5 yr 12 mo (1)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Old age infirmities</b>				5 yr	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>-----</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-----</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>-----</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <b>-----</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>-----</b>	

22. I hereby certify that I attended the deceased from **1948**, to **11-13, 1949**, that I last saw the deceased alive on **11-12, 1949**, and that death occurred at **2:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Chas H. Russell, M.D.</b> (Degree or title)		23b. ADDRESS <b>Louisiana, Mo.</b>		23c. DATE SIGNED <b>11-14-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11/15/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cem.</b>	
				24d. LOCATION (City, town, or county) (State) <b>Louisiana, Mo.</b>	

DATE REC'D BY LOCAL REG. <b>Nov 15, 1949</b>		REGISTRAR'S SIGNATURE <b>Bernice Collier</b>		25. GENERAL DIRECTOR'S SIGNATURE ADDRESS. <b>George O. Wagner, Louisiana</b>	
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RECEIVED NOV 28 1949  
District Health Officer No. 10  
District File Number 11-49-19  
Date Filed NOV 28 1949

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.~~

Student \_\_\_\_\_  
Student Embalmer

Signed George O. Wagner

Licensed Embalmer No. 3773

P. O. Address Louisiana, 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.