No. 300
10.48

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40270

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1425

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

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Joseph
c. LENGTH OF STAY (in this place): 30 min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Kansas
b. COUNTY: Doniphan 977
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Troy 14
d. STREET ADDRESS (If rural, give location): 0 2

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): W.
c. (Last): Reeder

4. DATE OF DEATH (Month) 12 (Day) 13 (Year) 1949

5. SEX: M 0
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12/31/1868
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months 11, Days 12 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney
10b. KIND OF BUSINESS OR INDUSTRY: Law
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: Isabel Reeder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME: Isabel Reeder — ADDRESS: Troy, Kansas

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) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. — 331X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-13, 1949, *to* 12-13, 1949, *that I last saw the deceased alive on* 12-13, 1949, *and that death occurred at* 9:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lucian W. Ide M.D.
23b. ADDRESS: 902 Edward St. St. Joseph, Mo.
23c. DATE SIGNED: 12/13/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 12/13/49
24c. NAME OF CEMETERY OR CREMATORY: Mt. Olive
24d. LOCATION (City, town, or county) (State): Troy, Kansas

DATE REC'D BY LOCAL REG.: Dec 28, 1949
REGISTRAR'S SIGNATURE: E. C. Jenkins 382
25. FUNERAL DIRECTOR'S SIGNATURE: C. L. Kane — ADDRESS: Troy, Kansas

(Licensed Embalmer's Statement on Reverse Side)

JUL 6 1954

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.....

Signed.....
Student Embalmer

Licensed Embalmer No. 3534

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.