

FILED JUL 31 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23319

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 669

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (in this place) 16 yrs		0396	
d. FULL NAME OF HOSPITAL OR INSTITUTION 920 St Louis		d. STREET ADDRESS (If rural, give location) 920 St Louis	

3. NAME OF DECEASED (Type or Print) a. (First) Florence b. (Middle) Reed c. (Last) Morgan			4. DATE OF DEATH (Month) (Day) (Year) July 28 1950			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept 6, 1856	9. AGE (In years last birthday) 93	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Ohio	12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME Robert Reed	13b. MOTHER'S MAIDEN NAME Caroline Tucker	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Clara Poland	ADDRESS Springfield, Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		7 hours
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Thrombosis DUE TO (c) _____		7 hours
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hobar Pneumonia		4 hrs 1 3 days?	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 27, 1950**, to **July 28, 1950**, that I last saw the deceased alive on **July 27, 1950**, and that death occurred at **2 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE Reineth C. Coffey M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 7-28-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE July 28, 1950	24c. NAME OF CEMETERY OR CREMATORY Unknown	24d. LOCATION (City, town, or county) (State) Leon, Iowa
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DATE REC'D BY LOCAL REG. 7-28-50	REGISTRAR'S SIGNATURE W E Handley	25. FUNERAL DIRECTOR'S SIGNATURE Ida Alma Schmeyer	ADDRESS Springfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

SEP 6

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 Bernard F. Wright

Signed _____
Student Embalmer

Licensed Embalmer No. 4293

P. O. Address Springfield, 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.