

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43772

State File No.

FILED JAN 3- 1952

BIRTH NO. REG. DIST. NO. 338 PRIMARY REG. DIST. NO. 6148 Registrar's No. 55

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

1. PLACE OF DEATH a. COUNTY Stoddard		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Castor		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Castor	
c. LENGTH OF STAY (in this place) Years		1030	
d. FULL NAME OF HOSPITAL OR INSTITUTION -----		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print)	a. (First) William	b. (Middle) Jackson	c. (Last) Reed	4. DATE OF DEATH (Month) (Day) (Year)	Dec. 20, 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 29, 1881	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 1	IF UNDER 12 HRS. Days 21	Hour Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Missouri 0	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME James S. Reed	13b. MOTHER'S MAIDEN NAME Mary Wilson	14. NAME OF HUSBAND OR WIFE Mary E. Reed
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. --	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lonnie Reed, Sikeston, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive heart disease DUE TO (c)		
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	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) (Min.)	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 Jan 1, 1946, to Dec 15, 1951, that I last saw the deceased alive on Dec 15, 1951, and that death occurred at 9:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. John D. Mo	23b. ADDRESS Bloomfield Mo	23c. DATE SIGNED Dec 27, 1951
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-22-51	24c. NAME OF CEMETERY OR CREMATORY Walkers Cemetery	24d. LOCATION (City, town, or county) (State) Bloomfield, Stoddard Mo.
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DATE REC'D BY LOCAL REG. Dec 27, 1951	REGISTRAR'S SIGNATURE Rose Wehner	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Chiles Und. Co. Bloomfield, Mo.
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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.....

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working under my personal supervision.

Student Embalmer No.....

Signed Lulu Cooper

Signed.....
Student Embalmer

Licensed Embalmer No. 3499

P. O. Address Bloomfield, 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.