

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37995

FILED NOV 6 - 1953

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>333</u>		PRIMARY REG. DIST. NO. <u>3074</u>		Registrar's No. <u>164</u>	
1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston, Mo.</u>		c. LENGTH OF STAY (in this place) <u>7 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Matthews</u>		d. STREET ADDRESS (If rural, give location) <u>-----</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>Thomas</u> c. (Last) <u>Reed</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10 - 21 - 1953</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>4-26-1879</u>	
				9. AGE (In years last birthday) <u>74</u>		IF UNDER 1 YEAR Month <u>5</u> Days <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Beach Creek, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Franklin Reed</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Gardner</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>E. C. Reed Matthews, Mo.</u>		
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) <u>Chr. Cor. Disease &amp; Aneurysm</u>					<u>2 1/2 wks</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Mitral Insufficiency</u>					<u>1 wks</u>
		DUE TO (c) <u>Pulmonary Edema</u>					<u>1 wks</u>
		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"/>	
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) <u>410 X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>10-13, 1953</u> , to <u>10/31, 1953</u> , that I last saw the deceased alive on <u>10-21, 1953</u> , and that death occurred at <u>1:25 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Thomas O. McClure</u>				23b. ADDRESS <u>Sebaston, Mo.</u>		23c. DATE SIGNED <u>10/22/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/23/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Sikeston, Mo</u>	
DATE REC'D BY LOCAL REG. <u>10-29-53</u>		REGISTRAR'S SIGNATURE <u>Mrs. Edna Hunter</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Henry Jones</u>		ADDRESS <u>Sebaston, Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED **NOV 4 1953**  
SCOTT COUNTY HEALTH CENTER  
CO. FILE NO. 1153-240

**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 John Allerton

Licensed Embalmer No. 2941

P. O. Address Sebaston

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

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