

FILED OCT 5 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32808

State File No.

BIRTH NO. _____ REG. DIST. NO. 338 PRIMARY REG. DIST. NO. 4566 Registrar's No. 76

1. PLACE OF DEATH a. COUNTY <u>Stoddard.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Essex</u>	c. LENGTH OF STAY (in this place) <u>50 yrs.</u>	c. CITY OR TOWN <u>Essex</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) <u>1030</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>James</u>	b. (Middle) <u>Albert</u>	c. (Last) <u>Reed</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 26, 1954</u>
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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>March 25, 1867</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drainage Contractor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Drain ditches</u>	11. BIRTHPLACE (City and State or Foreign Country) / <u>Cisne, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>James Reed</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Duke</u>	14. NAME OF HUSBAND OR WIFE <u>deceased</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>X X X</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Sarah Reed</u>	ADDRESS <u>Essex, Mo.</u>
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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 DISEASE AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertension High Blood Pressure</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>General Debility</u> 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 <u>444 X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Essex, Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input checked="" 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 Sept 20, 1954 to Sept 27, 1954, that I last saw the deceased alive on Sept 27, 1954, and that death occurred at 9:30 p.m. from the causes and on the date stated above.

23a. SIGNATURE <u>J.P. Duke M.D.</u>	23b. ADDRESS <u>Essex Mo</u>	23c. DATE SIGNED <u>9/27/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>9-28-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Gunion Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Cisne, Ill.</u>
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DATE REC'D BY LOCAL REG. <u>9/30/54</u>	REGISTRAR'S SIGNATURE <u>Louis E. Mooney</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Watkins Fun. Ser. Dexter, Mo.</u>	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

5020

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.....
Signature of Student Embalmer

Signed *Walter Marsh Watkins*.....

Licensed Embalmer No. *4717*.....

P. O. Address *Deerfield 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.