

FILED FEB 8 - 1955

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2259

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Madison</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Farmington</u> TOWN <u>Rural St. Francois</u>		c. CITY OR TOWN <u>Marquand</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>5 days</u>		e. STREET ADDRESS (If rural, give location) <u>0620</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>THOMAS</u>	b. (Middle) <u>B.</u>	c. (Last) <u>REED</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>January 13, 1955</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>Married</u>	8. DATE OF BIRTH <u>August 27, 1904</u>	9. AGE (In years last birthday) <u>50</u>	If UNDER 1 YEAR Months <u>4</u> Days <u>17</u>	If UNDER 2 HRS. Hours <u>17</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming; formerly licensed pharmacist</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Fort Scott, Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Hubbell Reed</u>	13b. MOTHER'S MAIDEN NAME <u>May Reilly</u>	14. NAME OF HUSBAND OR WIFE <u>Kate McDonald (2nd wife).</u>
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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>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Records, State Hospital No. 4, Farmington, Mo.</u>	ADDRESS
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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, asthenia, 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>Brain tumor</u>		<u>Unknown</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pneumonia</u>			<u>Abt. 48 hrs</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 January 8, 1955, to January 13, 1955, that I last saw the deceased alive on Jan. 13, 1955, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John A. Brennan, M.D.</u>	23b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u>	23c. DATE SIGNED <u>1-14-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan. 16, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Shady Grove Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Bald Knob, Ark.</u>
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DATE REC'D BY LOCAL REG. <u>Jan. 14, 1955</u>	REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home, Bald Knob, Ark.</u>	ADDRESS <u>Bald Knob, Ark.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 17 1958

NOV 5 1958

FEB 18 1958

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 *Paul H. Dwyer*

Licensed Embalmer No. *4170*

P. O. Address *Farmington*

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.