

1935 JUL 24 1935

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

21709  
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway 3 Registration District No. 104  
(b) Township Fulton 1 Primary Registration District No. 3008 Registered No. 190  
(c) City Fulton (d) Street No. State Hosp. #1 St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred 3 mos. 7 da. (f) How long in U. S., if of foreign birth yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 110 W. 3rd St., Sadalia Mo (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ida E. Reid

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 28 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
75 75 7 17

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. Railroad shop man  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation unknown

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Knox County Mo.

FATHER 13. NAME William Reid

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

MOTHER 15. MAIDEN NAME Catherine Reid

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) State Hosp #1 Fulton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Sadalia Mo DATE July 14 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Geo. Wallace Funeral Home Fulton Mo

20. FILED July 14 1939 R. N. Crews Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/14 1939

22. I HEREBY CERTIFY, That I attended deceased from April 30 1939 to July 14 1939  
I last saw him alive on July 13 1939 Death is said to have occurred on the date stated above, at 7:00 a.m.  
The principal cause of death and related causes of importance were as follows:

Bronchopneumonia Date of onset 7/13/39  
1073  
Other contributory causes of importance:  
Senile Raychois  
Malnutrition  
Dehydration

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? exam Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify: Yes J Wood, M. D.  
(Signed) State Hosp #1 Fulton Mo  
(Address) 106

WHITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X16625

---

**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.....

....., Registered Apprentice No.....

working under my personal supervision:

Signed *Harold J. Christey*

Licensed Embalmer No. *4002*

P. O. Address *Dulton, 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, above space should be left blank.**