

DEC 15 1939

Registration District No. 4 Primary Registration District No. 387 Registrar's No. 127

1. PLACE OF DEATH:  
(a) County Gasconade  
(b) City or town Washington, Highway 28, NW 1/4 of Section 1  
(c) Name of hospital or institution: none  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no 3  
In this community one day (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Franklin  
(c) City or town Washington  
(If outside city or town limits, write "RURAL")  
(d) Street No. 436 Stafford St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ✓ years.

3. (a) PRINT FULL NAME BERTHA VIOLA REED  
8. (b) If veteran, name war ✓ 8. (c) Social Security No. 493-01-0738  
5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
4. Sex Female 6. (b) Name of husband or wife William A. Reed Dead  
6. (c) Age of husband or wife if alive ✓ years  
7. Birth date of deceased June 28 1910  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month DEC day 10  
year 1939 hour 5 minute a. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
29 5 12 hr. min.

Immediate cause of death accidental death by auto mobile wreck Duration  
Due to Verdict of Coroners Jury

9. Birthplace Clover Bottom Missouri  
(City, town or county) (State or foreign country)  
10. Usual occupation Shoe Worker  
11. Industry or business International Shoe Co.  
MOTHER: 12. Name John F. Meyer  
13. Birthplace Clover Bottom Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Clara Hooper  
15. Birthplace Hotwell Missouri  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature Mrs. John F. Meyer  
(b) Address Washington, Missouri  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13 1939  
(Month) (Day) (Year)  
(c) Place: burial or cremation Washington, Mo.  
18. (a) Signature of funeral director Michael Witt, Jr.  
(b) Address Washington, Mo.  
19. (a) \_\_\_\_\_ (Date received local registrar) (b) E. A. Bunge, MD. (Registrar's signature) 915

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence 12-10-39  
(c) Where did injury occur? near Island Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Highway  
While at work? no (Specify type of place) (e) Means of injury Auto  
23. Signature E. A. Bunge, MD. (M. D. or other) Address Bland Mo Cron Date signed 12-10-39

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.

2/10/99

**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.....

..... *Me* ....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *Lester F. Vitt* .....

Licensed Embalmer No. *3254*

P. O. Address *Washington, 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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

39569

Do not use this space.

1. PLACE OF DEATH

(a) County Gasconade Registration District No. 302  
 (b) Township Clay Primary Registration District No. 6281  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Bertha Viola Reed

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 10 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

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

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

The principal cause of death and related causes of importance were as follows:

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.  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
 11. Total time (years) spent in this occupation \_\_\_\_\_

accidental death  
by automobile wreck  
judicial coroner jury  
collision with telephone  
post and a tree

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? g.i.d. m Was there an autopsy? \_\_\_\_\_

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?  
 If so, specify C. A. Burge coroner M. D.  
 (Signed) Bland mo  
 (Address) \_\_\_\_\_

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Local Registrar.

