

31 JAN 31 1940

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

42793
Do not use this space.

1. PLACE OF DEATH 3
 (a) County Buchanan Registration District No. 85
 (b) Township 2 Primary Registration District No. 1001 Registered No. 1269
 (c) City St. Joseph (d) Street No. State Hospital #2 St. Mo.
 (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 2 yrs. 6 mos. 0 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Geo. Reed
 (a) Residence, No. State Hospital #2 St. Kansas City, Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Margaret Reed

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 1880

7. AGE YEARS <u>59</u>	MONTHS <u>2</u>	DAYS <u>2</u>	IF LESS than 1 day,hrs. ormin.
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OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. painter

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Mo.

FATHER

13. NAME Julius Reed

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Mo.

MOTHER

15. MAIDEN NAME Elizabeth Stokes

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

17. INFORMANT Mrs. Margaret Reed 1508 1/2 Wyanokote K.C. Mo
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Joseph, Missouri
State Hospital #2 DATE December 11, 1939

19. FUNERAL DIRECTOR (NAME) Walter Meierhoffer
(ADDRESS) 1302 Faraon, St. Joseph, Missouri

20. FILED Dec 11 1939 D. Neel
26 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from 12/1 1939, to 12/7 1939
 I last saw him alive on 11.11.1939. Death is said to have occurred on the date stated above, at 3:45 a.m.
 The principal cause of death and related causes of importance were as follows:
chronic purulent bronchitis with broncho pneumonia
 Date of onset Aug 29

Other contributory causes of importance: 197W

Name of operation none Date of.....
 What test confirmed diagnosis? autopsy Was there an autopsy? yes

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.....
 (Signed) T. J. G. Hill M. D.
85 (Address) St. Joseph, Mo.

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.

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.....

Not Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *A. H. Kelly*.....

Licensed Embalmer No. *3946*.....

P. O. Address *St Joseph 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.