

FILED FEB 16 1940

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

11507  
Do not use this space.

1. PLACE OF DEATH

(a) County Adair 3 Registration District No. 4  
(b) Township Benton 0 Primary Registration District No. 5005 Registered No. 3  
(c) City Kirksville (d) Street No. Co. Infirmary 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 300 Byrd Reed 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

3. SEX male  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Loda Reed  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 18-1878  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
61 11 18  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Barber  
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) Kirksville Mo

FATHER 13. NAME James B. Reed

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

MOTHER 15. MARDEN NAME Sallie Linder

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

17. INFORMANT Dora B. Miller (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest DATE Jan 9, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Spencer L. Dreamer Kirksville Mo.

20. FILED Jan 8, 1940 Spencer L. Dreamer Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 6, 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1935, to Jan 6, 1940. I last saw him alive on Jan 5, 1940. Death is said to have occurred on the date stated above, at 12:30 P.m.  
The principal cause of death and related causes of importance were as follows:

Angina Pectoris (Coronary Occlusion)  
Chronic Alcoholism  
Date of onset Jan 6, 40  
9410

Other contributory causes of importance:  
Chronic Alcoholism

Name of operation..... Date of.....  
What test confirmed diagnosis?..... 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.....

(Signed) H. D. McAllister, M.D. (Address) Kirksville, Mo.

RECEIVED

District Health Officer No. 10

District File Number 2-40-418

Date Filed FEB 13 1940

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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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.