

WRITE 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

S.S.NO. UNKNOWN-IF ONE MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Dup of 31735-49
31746
Do not use this space.

1. PLACE OF DEATH
(a) County Clay Registration District No. 15
(b) Township Fishing River Primary Registration District No.
(c) City of Excelsior Springs, Mo. (d) Street No. Veterans Administration Facility St.
(e) Length of residence in city or town where death occurred yrs. mos. (f) How long in U. S., if of foreign birth? yrs. mos. da.
2. PRINT FULL NAME Conley Eastman REID
(a) Residence, No. Maysville, Mo. St. Maysville, 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. MARRIED, WIDOWED, OR DIVORCED Married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) November 14, 1894
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 45 9 28
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as saw mill, bank, etc. Unknown
10. Date deceased last worked at this occupation (month and year) Unknown
11. Total time (years) spent in this occupation Unknown
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Weatherby, Missouri
13. NAME Thomas Reid
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois
15. MAIDEN NAME Lucinda Thompson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Weatherby Missouri
17. INFORMANT Hospital Records
18. BURIAL, CREMATION, OR REMOVAL PLACE Winston, Mo. DATE 9-5-40
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Claude Prichard Excelsior Springs, Mo.
20. FILED 19 Local Registrar.

MEDICAL CERTIFICATE OF DEATH
21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 5, 1940
22. I HEREBY CERTIFY, That I attended deceased from 2-19-40, 19, to 9-5-40, 19.
I last saw him alive on Sept. 5, 1940. Death is said to have occurred on the date stated above, at 2:50 A.M.
The principal cause of death and related causes of importance were as follows:
Hypertension, arterial, systemic with myocardial damage and myocardial insufficiency
Other contributory causes of importance: Epilepsy, grand mal
Name of operation Spinal puncture Date of 2-29-40
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 Unknown
(Signed) W.A. GARDNER, M.D., Clinical Director
(Address) Veterans Administration Facility Excelsior Springs, Missouri

S(2)-31735

RECEIVED

District Health Officer No. 11,

District File Number _____

Date Filed _____

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 comply with the above constitutes grounds for revocation of license.)

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31735
31746

State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 198

Primary Registration District No. 3011

Registrar's No.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Spg
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Vets adm Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME Conley Eastman Reid

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>9</u>	<u>22</u>	hr. min.

9. Birthplace.....
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

{ 13. Birthplace.....
(City, town, or county) (State or foreign country)

{ 14. Maiden name.....

{ 15. Birthplace.....
(City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) 11-19-40 (b) Mrs Reid M Cracken
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....
(If outside city or town limits write "RURAL")

(d) Street No.....
(If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....
....., 19....., to....., 19.....;
that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

Duration.....

PHYSICIAN.....
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?.....
(Specify type of place) (e) Means of injury.....

23. Signature W. A. German (M. D. or other)
Address Excelsior Spg Mo

