No. 2
11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37821

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4419

FILED DEC 1 1940

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11-7-40-11-10-40 (Specify whether

In this community 30 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 1219 E. 22nd Street (If rural, give location)

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

3. (a) PRINT FULL NAME Harry Reed

3. (b) If veteran name war SS 496-09-1168 3. (c) Social Security No. unk

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary Reed 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased 9 (Month) 20 (Day) 1877 (Year)

8. AGE: Years 63 Months 1 Days 21 If less than one day ..... hr. ..... min.

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

10. Usual occupation Mortar Mixer

11. Industry or business

FATHER 12. Name Unknown

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

MOTHER 14. Maiden name Unknown

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

16. (a) Informant Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-40 (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Cem.

18. (a) Signature of funeral director Doyle Burke

(b) Address 1708 Tracy St.

19. (a) 11-19-40 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 10 year 40 hour 2 minute 45 A. M.

21. I hereby certify that I attended the deceased from 11-7- 1940 to 11-10- 1940 that I last saw him alive on 11-10- 1940 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Strangulated Inguinal Hernia (P.O.)	
Toxemia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 122	

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)

Address Gen. Hosp. #2 Date signed 11-16-40

(Licensed Embalmer's Statement on Reverse Side)

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 B. Graham

Licensed Embalmer No. 2540

P. O. Address 2208 Pine St.

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.