

Registration District No. **85** Primary Registration District No. **1001**

1. PLACE OF DEATH: **BUCHANAN**
(a) County **BUCHANAN**
(b) City or town **ST. JOSEPH**
(c) Name of hospital or institution **STATE HOSPITAL No. 2**
(d) Length of stay: In hospital or institution **47 yrs / 1 mo / 1 day**
In this community **47 yrs / 1 mo / 1 day**

3. (a) PRINT FULL NAME **HENRY CLAY REID**
(b) If veteran, name war **None** (c) Social Security No. **None**

4. Sex **Mal** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
7. Birth date of deceased **Oct 2nd 1870**

8. AGE: Years **70** Months **2** Days **17** If less than one day hr. min.

9. Birthplace **Carroll Co. Mo.**
10. Usual occupation **Farmer**

MOTHER FATHER
11. Industry or business
12. Name **Sylvanus B. Reid**
13. Birthplace **Unknown Kentucky**
14. Maiden name **Martha A. Fuling**
15. Birthplace **Unknown Rhode Island**

16. (a) Informant **Hospital Records**
(b) Address **State Hosp #2, St. Joseph**
17. (a) **Removal** (b) Date thereof **12/19/40**

(c) Place: burial or cremation **Carrollton Mo.**
18. (a) Signature of funeral director **Walter Bowman**
(b) Address **319 So. 1st St. St. Joseph**
19. (a) **12/20/40** (b) **[Signature]**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Carroll**
(c) City or town **Carrollton**
(d) Street No. **[Blank]**
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec**, day **19th**, year **1940** hour **2** minute **40** P. M.
21. I hereby certify that I attended the deceased from **Dec. 12**, 19**40** to **Dec. 19**, 19**40**; that I last saw him alive on **Dec. 19**, 19**40**; and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia -**
fracture of femur
Due to **fracture of femur**
Due to **[Blank]**
Other conditions **Paranoia**
Major findings: Of operations **no**
Of autopsy **no**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **accident**
(b) Date of occurrence **12-17-40**
(c) Where did injury occur? **St. Joseph Buchanan Mo.**
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
State Hospital # 2
While at work? **[Blank]** (a) Means of injury **Fall**
23. Signature **Kenneth [Signature]** M. D.
Address **State Hosp #2 St. Joseph** Date signed **12-19-40**

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

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 7-12-19-40

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

Signed Wm E Summers

Licensed Embalmer No. 3007

P. O. Address 319 Sac 10 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, fact should be so stated above.