

No. 2  
-1-4-41  
5-17-39  
I X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

21173

State File No. \_\_\_\_\_

Registration District No. 35

Primary Registration District No. 2001

Registrar's No. 531

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:  
122 1/2 S. 3rd.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
years, months or days) 40 Years

3. (a) PRINT FULL NAME WALTER WILLIAM REID

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced, widowed widowed

6. (b) Name of husband or wife unknown

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 12th. 1862  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>78</u>	<u>7</u>	<u>6</u>	hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Reid

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

14. Maiden name Unknown

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

16. (a) Informant Old Age Records

(b) Address St. Joseph, Mo.

17. (a) Burial (b) Date thereof 6--21--41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) June 20 1941 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan

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

(d) Street No. 122 1/2 S. 3rd.  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18th.  
year 1941 hour 7 minute 00 p. m.

21. I hereby certify that I attended the deceased from on  
June 20, 1941 to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Mitral insufficiency Chronic 1 year  
Due to Chronic Multiple Sclerosis 10 years

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) g212

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy no

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)

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

Address 464 So 3rd ST. JOSEPH Date signed 6/20/41

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.....

*Dean Owens*

Registered Apprentice No. *283*

working under my personal supervision.

Signed.....

*W. J. Fleming*

Licensed Embalmer No. *1748*

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, fact should be so stated above.**