S.
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 8 1944

Registration District No. 274

THE STATE BOARD OF HEALTH OF MISSOURI.

STANDARD CERTIFICATE OF DEATH

35020

State File No.

Primary Registration District No. 3052

Registrar's No. 353

1. PLACE OF DEATH:

(a) County Pettis

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

(c) Name of hospital or institution: 135 East Chestnut
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pettis 20

(c) City or town Sedalia 6
(If outside city or town limits, write "RURAL") 4

(d) Street No. 135 East Chestnut
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Helen Marie Reed

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife *****

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

7. Birth date of deceased September 28, 1931
(Month) (Day) (Year)

8. AGE: Years 13 Months 1 Days 3 If less than one day hr. min.

9. Birthplace Lamonte, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business none

FATHER
12. Name Clarence R. Reed
13. Birthplace Pettis County, Mo. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lena Sprinkles
15. Birthplace Pettis County, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence Reed (father)

(b) Address 135 E. Chestnut, Sedalia, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/44
(Month) (Day) (Year)

(c) Place: burial or cremation Lamonte Cemetery

18. (a) Signature of funeral director EWING FUNERAL HOME

(b) Address Sedalia, Mo.

19. (a) 11/2/44 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct. day 31, year 1944 hour 12:30 minute P. M.

21. I hereby certify that I attended the deceased from 28 Oct 1944 to Oct 31 1944 that I last saw her alive on Oct 29 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchical Pneumonia

Due to Influenza

Due to Congenital Spina bifida

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.

157b

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 0

23. Signature E C Linwell (M. D. or other)

Address Sedalia Date signed Nov 2-44

1022 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 11-7-44

Dr. Sawyer

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 Duane Ewing

Licensed Embalmer No. 3847

P. O. Address Sedalia 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.

No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. None

Registration District No. 274 Primary Registration District No. 3092 Registrar's No. 353

1. PLACE OF DEATH:
(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Helen M. Reed
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 28 1931 (Month) (Day) (Year)

8. AGE: Years 13 Months 1 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 11-2-44 (Date received local registrar) (b) Mrs Anna Berger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3, year 1944 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 — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

35020