V. S. No. 2
50M—9-4-41
Rev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 15 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40758

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 420

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9M - 10d (Specify whether
In this community 9M — 10d years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 14
(c) City or town Kansas City 1
(If outside city or town limits, write "RURAL")
(d) Street No. 2373 Park Ave 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah Reid

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

4. Sex F 3
5. Color or race N
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased MAY (Month) 15 (Day) 1877 (Year)

8. AGE: Years 68 Months 7 Days 11 If less than one day hr. min.

9. Birthplace Malta Bend, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Cook & laundress
11. Industry or business

FATHER
12. Name Jake Hull
13. Birthplace Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elsa Whipps
15. Birthplace Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant Cloud Reid
(b) Address 2513 Park Ave, Kansas City
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-45 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Kansas City, Mo.
18. (a) Signature of funeral director West, Appleton & Jones
(b) Address Kansas City, Mo.
19. (a) Dec 29-1945 (Date received local registrar) (b) Josef Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26 year 1945 hour 11:20 A M.

21. I hereby certify that I attended the deceased from 4-12, 1945, to 12-26-, 1945 that I last saw her alive on 12-26, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Paresis

Due to Generalized arterio-sclerosis

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

23. Signature J. B. Stokes, M.D. (M. D. or other)
Address Fulton Date signed 12/29/45

1141 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 1-14-46

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 Eli Bell

Licensed Embalmer No. 2130

P. O. Address Fulton 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.