DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 15 1946

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

DR. Hope

State File No. 41616

Registration District No. 170

Primary Registration District No. ~~3038~~ 5636

Registrar's No.

**1. PLACE OF DEATH:**

(a) County LACLEDE

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

(c) Name of hospital or institution: PHILLIPSBURG R.I. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ——— (Specify whether
In this community 3½ YRS
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MO (b) County LACLEDE 53

(c) City or town RURAL 0
(If outside city or town limits, write "RURAL")

(d) Street No. PHILLIPSBURG R.I. 0
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME ANN M. REED

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

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

6. (b) Name of husband or wife ALBERT REED

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

7. Birth date of deceased NOV (Month) 22 (Day) 1854 (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 91 | 1 | 7 | hr. min. |

9. Birthplace CLAY ST. JOSEPH CO. IND. 1
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name THOS. H. SMITH
13. Birthplace N.J. 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name CLARISA BEARDSLEY
15. Birthplace Ohio 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Archie B. Chew
(b) Address R.I. PHILLIPSBURG MO

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 1-1-46 (Month) (Day) (Year)
(c) Place: burial or cremation LAPORTE IND

18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO.

19. (a) 1-8-46 (Date received local registrar) (b) Ora Frankeberger (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month DEC day 29
year 1945 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from 4/12, 1943 to 12/29, 1945
that I last saw her alive on Dec 28, 1945
and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Lobar pneumonia lower rt. lobe | 3 days |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

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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 James L. Hope, (M. D. ~~or other~~)
Address Lebanon, Mo. Date signed 1/4/46.

1463 (Licensed Embalmer's Statement on Reverse Side)

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

Received
Laclede County Health Unit
File No. 12-45-190
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 D. A. Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**