

No. 2
8-13
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9500
Registrar's No. 187

FILED MAR 18 1946

Registration District No. 158

Primary Registration District No. 5590

1. PLACE OF DEATH:

(a) County JEFFERSON
(b) City or town RURAL
(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 _____)
In this community 80 YRS
years, months or days

3. (a) PRINT FULL NAME LUCY VIRGINIA REED
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife CLEMENT REED
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 12 1858
(Month) (Day) (Year)

8. AGE: Years 87 Months 9 Days 20
If less than one day _____ hr. _____ min.

9. Birthplace FRANKLIN COUNTY MO. U
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business HOME

12. Name JOHN M. PERKINS

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

14. Maiden name VIRGINIA SARGENT

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

16. (a) Informant William Frost

(b) Address GRUBVILLE MO

17. (a) BURIAL (b) Date thereof MAR 4 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GRUBVILLE MO

18. (a) Signature of funeral director Chas + Lend

(b) Address ST. CLAIR, MO

19. (a) Mar 9-46 (b) A. H. Eator
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County FRANKLIN 36
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 2nd day 2nd month March
year 1946 hour 9:45 minute _____ A.M.

21. I hereby certify that I attended the deceased from _____, 19____, 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: Old, unhealed fracture of left leg.
Due to Septicemia and coronary failure
Due to Atherosclerosis

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) fractured leg 5D

(b) Date of occurrence Oct-7th 1946 - edd 1946

(c) Where did injury occur? at her home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home, near Grubville rd

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

23. Signature A. P. Edwards (M. D. or other) _____

Address Cedar Hill Mo Date signed 3/3/46

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

MOTHER FATHER

140

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 H. M. Lerot

Licensed Embalmer No. 3601

P. O. Address St Clair, 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.