

FILED SEP 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26111

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1007

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) St Joseph	c. LENGTH OF STAY (In this place) Mys Smo 23	c. CITY (If outside corporate limits, write RURAL and give township) Kansas Cente 3178	
d. FULL NAME OF HOSPITAL OR INSTITUTION Male Hospital no 2		d. STREET ADDRESS (If rural, give location) 1104 Olive Dept 1 1950	

3. NAME OF DECEASED (Type or Print) Sarah	a. (First)	b. (Middle) E	c. (Last) Reed	4. DATE OF DEATH (Month) (Day) (Year) 9-1-1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec 23-1867	9. AGE (In years last birthday) 82	# UNDER 1 YEAR 8	# UNDER 1 MONTH 8	# UNDER 1 HOUR 8
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Platte Co. Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Chas H. Harper	13b. MOTHER'S MAIDEN NAME Julia Miller	14. NAME OF HUSBAND OR WIFE Charles Reed
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME State Hosp #2 St. Joseph, Mo	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Interochondric fracture of rgt femur. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		#	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) on stove	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 25 1950 3a.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fall by her bed 131
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22. I hereby certify that I attended the deceased from Aug 1, 1950, to Sept 1, 1950, that I last saw the deceased alive on Sept 1, 1950, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Forrest Thomas M.D.	23b. ADDRESS St Joseph M. & Male Hospital no 2	23c. DATE SIGNED Sept 1 1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-2-1950	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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DATE REC'D BY LOCAL REG. Sept 8, 1950	REGISTRAR'S SIGNATURE K. C. Jenkins 382	25. FUNERAL DIRECTOR'S SIGNATURE Herman W. Schaefer	ADDRESS 1802 Union
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COPY OVERLAPPING 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 _____

working under my personal supervision.

Student Embalmer No.

Signed *Elmer Phouca*

Signed.....
Student Embalmer

Licensed Embalmer No. *2640*

P. O. Address *St. Joseph*

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

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