

FILED NOV 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32617

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 5112 3006 State File No. _____ Registrar's No. 273

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hallsville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hallsville</u>	
c. LENGTH OF STAY (In this place) <u>6 Years</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED (Type or Print) a. (First) <u>FRIEDA</u> b. (Middle) <u>KATHRINE</u> c. (Last) <u>REA</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 1, 1950</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 4, 1878</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Freeburg, Illinois.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>

13a. FATHER'S NAME <u>Charles L. Scheid</u>	13b. MOTHER'S MAIDEN NAME <u>Margaretha Heigele</u>	14. NAME OF HUSBAND OR WIFE <u>G.M. REA. Hallsville Mo</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. D.B. Carpenter, Hallsville, Mo.</u>

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>10-20-50</u> <u>Year</u> <u>Year.</u> <u>592x</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Glomerular Nephritis</u> DUE TO (c) <u>Arterial Hypertension</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>11-1-50</u>	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 10-16-50, 1950, to 11-1-50, 1950, that I last saw the deceased alive on 10-30-50, and that death occurred at 5:30A m., from the causes and on the date stated above.

23a. SIGNATURE <u>P. O. Baker, M.D.</u>	(Degree or title)	23b. ADDRESS <u>Centralia Mo</u>	23c. DATE SIGNED <u>11-1-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	24b. DATE <u>Nov. 3, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Crematory</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>

DATE REC'D BY LOCAL REG. <u>Nov. 3 1950</u>	REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Parker Funeral Service Columbia Mo</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 11-6-50

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 11-6-50

DEC 5 1950

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 *M. J. Phillips*

Signed _____
Student Embalmer

Licensed Embalmer No. 3893

P. O. Address *Columbia*

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.