

FILED DEC 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40316

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 113 PRIMARY REG. DIST. NO. 5431 Registrar's No. 45

0360

WRITE PLAINLY—USING INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Prairie</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural - Prairie</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robertsville - Mo. B. H.</u>		d. STREET ADDRESS (If rural, give location) <u>Robertsville - Mo. B. H.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Arthur</u> b. (Middle) <u>William</u> c. (Last) <u>Reid</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>12-6-50</u>
---	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>W. Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-30-1889</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>61 0 6</u>
-----------------------	-------------------------------------	--	---------------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life or in if retired) <u>W.P.A.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Mo - 0</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	--	--

13a. FATHER'S NAME <u>W. E. Reid</u>	13b. MOTHER'S MAIDEN NAME <u>Ada G. Olds</u>	14. NAME OF HUSBAND OR WIFE <u>Emma</u>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>444-12-4287</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Emma Reid - Robertsville</u>	ADDRESS <u>Robertsville</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, atherosclerosis, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of lung -</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Broken Splintered Rib</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>490</u>			

19a. DATE OF OPERATION <u>June 1950</u>	19b. MAJOR FINDINGS OF OPERATION <u>Cancer of lung -</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	---	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident - Fall</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <u>Prairie Twp - Franklin Mo</u>
--	---	---

21d. TIME OF INJURY <u>12-2-45a. m.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fell from scaffold -</u>
--	---	---

22. I hereby certify that I attended the deceased from 12/2-1946 to 12/6-1950 and that death occurred 430 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>W. E. Kitchell - M.D.</u>	23b. ADDRESS <u>St. Clair - Mo</u>	23c. DATE SIGNED <u>12/7/50</u>
--	---------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12-9-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	24d. LOCATION (City, town, or county) (State) <u>Franklin Mo</u>
--	-----------------------------	--	---

DATE REC'D BY LOCAL REG. <u>12-7-1950</u>	REGISTRAR'S SIGNATURE <u>E. L. Worthington</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Siemens & Kitchell</u>	ADDRESS <u>St. Clair</u>
--	---	---	-----------------------------

File No. _____

DISTRICT HEALTH OFFICE No. 4

DEC 26 1950

RECEIVED

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____

Student Embalmer

Signed _____

Sherrill W. Kitchel

Licensed Embalmer No. 3873

P. O. Address St. Clair

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.