

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41737

State File No. _____

FILED DEC 29 1950

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 4406 Registrar's No. 390

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

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Albert</u>	b. (Middle) <u>Pitman</u>	c. (Last) <u>Reid</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>12 12 50</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u>	8. DATE OF BIRTH <u>Feb 21 1870</u>	9. AGE (In years last birthday) <u>80</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Rock Port Co. Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Wm Reid</u>	13b. MOTHER'S MAIDEN NAME <u>America Rapp</u>	14. NAME OF HUSBAND OR WIFE <u>Martha Shorter</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Martha Reid</u>	ADDRESS <u>Houstonia</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma lower jaw</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>✓</u>		

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) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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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? _____
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22. I hereby certify that I attended the deceased from me, 1950, to 12/12, 1950, that I last saw the deceased alive on 12/11, 1950, and that death occurred at _____ m., from the causes and on the date stated above.

23. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>M.D. - Marshall</u>	23b. ADDRESS <u>Mo</u>	23c. DATE SIGNED <u>12/13/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>12-15-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Houstonia</u>	24d. LOCATION (City, town, or county) (State) <u>Houstonia Mo</u>
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DATE REC'D BY LOCAL REG. <u>12-15-1950</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Houstonia</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED

12/27/50

DISTRICT I

District

Date Filed 12/27/50

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 H. H. Smiley

Licensed Embalmer No. 3987

P. O. Address Houstonia

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.