

FILED JUL 23 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25968

BIRTH NO. _____		REG. DIST. NO. 360		PRIMARY REG. DIST. NO. 6225		Registrar's No. 67	
1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Hickory</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Wash. Township</u>		c. LENGTH OF STAY (in this place) <u>4 mo. 18 d.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Flemington</u>		OR TOWN <u>0430</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital Nevada Mo.</u>				d. STREET ADDRESS (If rural, give location) <u>unknown</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES -</u> b. (Middle) <u>P -</u> c. (Last) <u>REED</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 11, 1951</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married - 1</u>		8. DATE OF BIRTH <u>March 2, 1866</u>	
9. AGE (In years last birthday) <u>85</u>		10. UNDER 1 YEAR Months <u>4</u> Days <u>9</u>		11. BIRTHPLACE (State or foreign country) <u>Hickory County Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>f. farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>			13. FATHER'S NAME <u>John W. Reed</u>	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME <u>Sara E. Roundtree</u>			14. NAME OF HUSBAND OR WIFE <u>Etta Reed</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>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records State Hospital Nevada 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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic</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) <u>Heart Disease</u>				DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senile Psychosis - Fracture right hip 4-19-51</u>							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>fall on road</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>on ward State Hospital Nevada</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Vernon Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>4-19-51 A.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>while walking - slipped and fell</u>			
22. I hereby certify that I attended the deceased from <u>Feb 23, 1951</u> , to <u>July 11, 1951</u> , that I last saw the deceased alive on <u>July 11, 1951</u> , and that death occurred at <u>6:00 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Paul L. Barone M.D.</u>				23b. ADDRESS <u>State Hospital 3 Nevada Mo.</u>		23c. DATE SIGNED <u>July 11/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>7-11-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Humansville</u>		24d. LOCATION (City, town, or county) (State) <u>Humansville Mo.</u>	
DATE REC'D BY LOCAL REG. <u>7-13-1951</u>		REGISTRAR'S SIGNATURE <u>Bernard E. Ferry 451</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Purnell Funeral Home Humansville</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

080
2

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED

JUL 18

Dist. File

Date Filed

25-1-25-2
7-18-24

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

O. H. Beckwith

Signed.....
Student Embalmer

Licensed Embalmer No.

3957

P. O. Address

Humansville

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.