

FILED SEP 7 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26709

|  |  |  |   |  |   |  |  |
|--|--|--|---|--|---|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>98</u>   |   | PRIMARY REG. DIST. NO. <u>4164</u>   |   | Registrar's No. <u>81</u>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Davess</u>   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If in institution: residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>Davess</u> |   |  |  |
| b. CITY OR TOWN <u>Alta Mont</u>   |  | c. LENGTH OF STAY (in this place) <u>4 years</u>   |   | c. CITY OR TOWN <u>Alta Mont</u>   |   | d. STREET ADDRESS (If rural, give location) <u>0310</u>              |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION  |  |  |   | d. STREET ADDRESS  |   |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Hudson</u> b. (Middle) <u>Lunsford</u> c. (Last) <u>Ried</u>  |  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>8-27-54</u> |  |   |  |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u>  |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>W</u>   |   | 8. DATE OF BIRTH <u>9-18-1876</u>                                    |  |
| 9. AGE (In years last birthday) <u>77</u>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired farmer Mo</u> |   | 11. BIRTHPLACE (City and State or Foreign Country) <u>Mo</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                           |  |
| 13a. FATHER'S NAME <u>Flint Ried</u>   |  |  | 13b. MOTHER'S MAIDEN NAME <u>Forsinger</u>              |  | 14. NAME OF HUSBAND OR WIFE <u>Minnie Ried</u>                                      |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |  | 16. SOCIAL SECURITY NO. <u>none</u>                     |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Wm. O'Neil 235 So. Dan W. W. W.</u> |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.   |  |  |   |  |   |  |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>30 min</u>  |   |  |  |
| ANTECEDENT CAUSES<br>As forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>arterial Sclerosis, cerebral Hemorrhage</u><br>DUE TO (c) <u>3 years, nocturnal grand mal epilepsy</u>                   |  |  |   |  |   |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION<br><u>4201</u>  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input 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) (Minute)   |  | 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 <u>June 1920</u> to <u>8/27</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>8/25</u> , 19 <u>54</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above. |  |  |   |  |   |  |  |
| 23a. SIGNATURE <u>J. M. Bailey D.D.</u> (Degree of title)  |  |  |   | 23b. ADDRESS <u>Callahan, Mo.</u>  |   | 23c. DATE SIGNED <u>9-3-54</u>                                       |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 24b. DATE <u>8-30-54</u>   |   | 24c. NAME OF CEMETERY OR CREMATORY <u>Alta Mont</u>  |   | 24d. LOCATION (City, town, or county) (State)<br><u>Alta Mont Mo</u> |  |
| DATE REC'D BY LOCAL REG. <u>9-4-54</u>   |  | REGISTRAR'S SIGNATURE <u>Virginia M. Engelbert</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Wate Street Waukegan Mo</u>   |   |  |  |

WRITE PLAINLY—USING UNFADING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Harrie A. Bram

Licensed Embalmer No. 3918

P. O. Address Hamilton, Mo.

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.

EP 6.4