

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31568**

FILED SEP 18 1956

BIRTH NO. _____ REG. DIST. NO. **265** PRIMARY REG. DIST. NO. **L292** Registrar's No. **30**

1. PLACE OF DEATH a. COUNTY Ozark		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Unknown	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Thornfield		c. CITY OR TOWN Fredonia	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 3 Days		• STREET ADDRESS (If rural, give location) 415 9	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) Samuel Joseph b. (Middle) Reed c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Sept. 4, 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Feb. 26, 1896	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Taney County, Missouri	
12. CITIZENRY OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Joseph Reed	13b. MOTHER'S MAIDEN NAME Hannah Humbyrd	14. NAME OF HUSBAND OR WIFE Grace Reed
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War Two	16. SOCIAL SECURITY NO. 515 12 8097	17. INFORMANT'S SIGNATURE OR NAME Jesse Reed, Fredonia, Kansas	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) No physician in attendance prophylax DUE TO (b) Coronary Thrombosis DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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) 4.201
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **6: A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Death of Male) Thana Mahan	23b. ADDRESS L.R. Hainesville	23c. DATE SIGNED 9-15-56
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24a. BURIAL CREMATION REMOVAL (Specify) BURIAL	24b. DATE 9-15-56	24c. NAME OF CEMETERY OR CREMATORY Thornfield	24d. LOCATION (City, town, or county) (State) Thornfield Mo.
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DATE RECD BY LOCAL REG. 9-18-56	REGISTRAR'S SIGNATURE Thana Mahan	25. FUNERAL DIRECTOR'S SIGNATURE Clinkingbeard Funeral Home, Ava, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

461

1203
907 2

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.....
Signature of Student Embalmer

Signed *Wyle G. Linkinghead*.....

Licensed Embalmer No. *9830*.....

P. O. Address *Rich. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

