S. No. 2
M—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

#2 6286

State File No. 677

Registration District No. FILED FEB 24 1949 Primary Registration District No. 1002 Registrar's No.

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 hr. (Specify whether
In this community 2 Hours
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 13

(c) City or town Polo 0
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3. (a) PRINT FULL NAME** WALTER-KEITH REED

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased FEBRUARY 8 - 1944
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| - | — | — | — | 8 hr. min. |

9. Birthplace Kansas City (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation infant

11. Industry or business

FATHER
12. Name Lowell Keith Reed
13. Birthplace Iowa (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Peggy Joan Partright
15. Birthplace Kansas City (City, town, or county) Mo-0 (State or foreign country)

16. (a) Informant Lowell Keith Reed
(b) Address U. S. Navy

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-11-44 (Month) (Day) (Year)
(c) Place: burial or cremation Sidney Iowa

18. (a) Signature of funeral director Freeman Mortuary
(b) Address 104 West 42nd street

19. (a) 2-10-44 (Date received local registrar) (b) R. E. Brown (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 8th
year 1944 hour 3 AM minute M.

21. I hereby certify that I attended the deceased from 1:07 PM Feb. 8, 1944 to Feb. 8, 1944
that I last saw him alive on Feb. 8, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to 6 months preg.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

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Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? —
(Specify type of place)
While at work? — (e) Means of injury 0

23. Signature Eugene H. Ferguson (M. D. or other)
Address 933 Prof Bldg Date signed 2-10-44

(Licensed Embalmer's Statement on Reverse Side)

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## 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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**