. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23715

FILED AUG 8 1947

Registration District No. 92

Primary Registration District No. 4289

Registrar's No. 85

1. PLACE OF DEATH:

(a) County CLAY

(b) City or town SQUIRE HIGHTS ADDN, NORTH KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.R.#8 SHERIDAN ROAD 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 25 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLAY 24

(c) City or town SQUIRE HIGHTS ADD NORTH, KANSAS CITY 0
(If outside city or town limits, write "RURAL")

(d) Street No. RR#8 SHERIDAN ROAD 0
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 0

If yes, name country .....

3. (a) PRINT FULL NAME RALPH EMERSON REED

3. (b) If veteran, name war NO

3. (c) Social Security No.

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife MRS. HESTER E. REED

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased SEPTEMBER (Month) 4 (Day) 1895 (Year)

8. AGE: Years	Months	Days	If less than one day
51	10	0	..... hr. ..... min.

9. Birthplace UNKNOWN (City, town, or county) OHIO (State or foreign country) 1

10. Usual occupation POULTRY TECHNICIAN

11. Industry or business SPEAR MILLS, INC.

FATHER
12. Name EDWIN C. REED
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name ANNA
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country) 9

16. (a) Informant MRS. HESTER E. REED
(b) Address R.R. 8 SHERIDAN ROAD

17. (a) CREMATION (Burial, cremation, or removal) (b) Date thereof 7 7 1947 (Month) (Day) (Year)
(c) Place: burial or cremation D. W. NEWCOMERS SONS.

18. (a) Signature of funeral director D. W. Newcomer's Sons
(b) Address 1401 BROSH CREEK BLVD.

19. (a) July 7-1947 (Date received local registrar) (b) Beulah Kitchen (Registrar's signature) 63

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 4TH year 1947 hour 11:30 minute P. M.

21. I hereby certify that I attended the deceased from 5-15-43 ....., 19...., to death ....., 19....; that I last saw him alive on 6-23-4- ....., 19....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	1 hr.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

94 A

PHYSICIAN

Underline the cause of 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 R. H. Dunham MD (M. D. or other)

Address NKC, Mo Date signed 7/5/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number.....

Date Filed 8-7-47

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 John E. Graking, Registered Apprentice No. 504, working under my personal supervision.

Signed E. Oscar Hoskey

Licensed Embalmer No. 1767

P. O. Address Kansas City

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.