

with, Welfare  
Public  
Service

FILED JUN 12 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

173110  
STATE FILE NUMBER  
2494

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 2494

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
c. FULL NAME OF (If NOT in hospital, give location) <b>ST. JOSEPH HOSPITAL</b>		d. STREET ADDRESS <b>1809 EAST 58th STREET</b>	

3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>V.</b> Last <b>REED</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>25</b> Year <b>1957</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 26, 1904</b>	9. AGE (In years last birthday) <b>52</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARRIER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. POST OFFICE</b>	11. BIRTHPLACE (City and state or country) <b>PENNSYLVANIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>MATTHEW W. REED</b>	13b. MOTHER'S MAIDEN NAME <b>MAUDE SANDERS</b>	14. NAME OF HUSBAND OR WIFE <b>BEULAH REED</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MRS. BEULAH REED</b> Address <b>1809 E. 58th St. K.C. Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years 15 1/2</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <b>Carcinoma Stomach</b>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? <b>NO</b>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>5-25-57</b> to <b>death</b> and last saw her alive on <b>May 25<sup>th</sup> 1957</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>F. A. Carmichael M.D.</b> (Degree & title) <b>0</b>	22b. ADDRESS <b>411 Nichols Rd.</b>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>MAY 28, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS</b> ADDRESS <b>KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>5-28-57</b>	26. REGISTRAR'S SIGNATURE <b>Reva Marshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

F. A. Carmichael

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms or signs of disease in Part I must be causally related.



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 *Chester K Brown*

Licensed Embalmer No. *493*  
P. O. Address *10 E 11*

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.