

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32125

STATE FILE NUMBER

FILED SEP 24 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4121

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>3709 St. John</u> HOSPITAL OR INSTITUTION		Length of stay in 1b <u>54 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>3709 St. John</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lilly</u> Middle <u>B.</u> Last <u>REID</u>			4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-1868</u>
9. AGE (In years, Months, Days) <u>88</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>K. C., Kansas</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Gibbons</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>J.P. Reid</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Mrs. Ruby Gibbons</u> Address <u>Webb City, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Generalized Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u> <u>10 days.</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) <u>Arteriosclerotic Heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <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 _____	
21. I attended the deceased from <u>7-24-57</u> , to <u>8-29-57</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>8-29-57</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert L. Stark, M.D.</u> (Print or title)		22b. ADDRESS <u>4126 St. John</u>	
22c. DATED <u>8-30-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sept. 3-1957</u>		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY <u>W. Marsh Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
24. FUNERAL DIRECTOR <u>C. H. Blackman &amp; Son Inc.</u> ADDRESS <u>K.C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-3-57</u>	
		26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.  
Robert L. Ward

(Licensed Embalmer's Statement on Reverse Side)

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 *Bert P. Bennett* .....

Licensed Embalmer No. *4656* .....

P. O. Address *H. C. 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.