

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013399

STATE FILE NUMBER

FILED MAY 1 1958

Registration District No. 43

Primary Registration District No. 3007

Registrar's No. 334

5. 300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Butler</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY <u>Butler</u>                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                               | c. CITY OR TOWN <u>Poplar Bluff, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                           |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lucy Lee Hosp.</u> Length of stay in 1b  |                               | d. STREET ADDRESS (If outside, give location) <u>Hwy 67 South</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First <u>John</u> Middle <u>Francis</u> Last <u>Reid</u>   |                               |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>15</u> Year <u>1958</u>                          |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH <u>Feb. 8, 1902</u>   |
| 9. AGE (In years last birthday) <u>56</u>   |                               | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u>   | IF UNDER 24 HRS.<br>Hours <u>0</u> Min. <u>0</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Painter &amp; Auto</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>repair</u>  | 11. BIRTHPLACE (City and state or country) <u>Perthamboy, New Jersey</u>                       |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |                               | 13a. FATHER'S NAME <u>Frank V. Reid</u>  |  |
| 13b. MOTHER'S MAIDEN NAME <u>Margaret Bergen</u>  |                               | 14. NAME OF HUSBAND OR WIFE <u>Janette Eliason 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. <u>493-07-1466</u>   | 17. INFORMANT Address <u>Mrs. J.F. Reid, Poplar Bluff, Mo.</u>                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary infarction</u>   |                               |  | INTERVAL BETWEEN ONSET AND DEATH <u>Approx. 5 min.</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Congestive failure</u>   |                               |  | <u>Present for months</u>  |
| DUE TO (c) _____  |                               |  | <u>4201</u>  |
| 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? 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<br>Hour _____ a.m. _____ p.m.   |                               | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>4/10/58</u> to <u>4/15/58</u> and last saw her alive on <u>4/14/58</u><br>Death occurred at <u>5:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |                               |  |  |
| 22a. SIGNATURE (Degree or title) <u>J.R. Loughead, M.D.</u>   |                               | 22b. ADDRESS <u>330 N. 2nd St. - Poplar Bluff, Mo.</u>   | 22c. DATE SIGNED <u>4/21/58</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE <u>4-19-58</u>      | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Gardens</u>   | 23d. LOCATION (City, town, or county) (State) <u>Poplar Bluff, Mo.</u>                         |
| 24. FUNERAL DIRECTOR ADDRESS <u>Frank-Cotrell Poplar Bluff, Mo.</u>   |                               | 25. DATE RECD. BY LOCAL REG. <u>4/26/58</u>  | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |

RECEIVED

AFF 2 1956 AFF 2 1956  
BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

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 Donald Roberts

Licensed Embalmer No. 4927  
P. O. Address Poplar Bluff

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.