Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014305
STATE FILE NUMBER

FILED MAY 13 1959 Registration District No. 270 Primary Registration District No. 3050 Registrar's No. 32

1. PLACE OF DEATH
a. COUNTY: Pemiscot
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Caruthersville — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Home — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY: Pemiscot
c. CITY OR TOWN: Caruthersville 0782 0 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1009 Laurant Ave. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Frank — Middle: J. — Last: Reed

4. DATE OF DEATH: Month: April — Day: 26 — Year: 1959

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] 0
8. DATE OF BIRTH: Oct, 17, 1904
9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months 6, Days 9 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Caruthersville, Mo. 0
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: John Reed
13b. MOTHER'S MAIDEN NAME: Bell Dillman
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. W. II
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Dottie Shaw 920 Beckwith C'ville.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): DOA — INTERVAL BETWEEN ONSET AND DEATH: 30 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): unknown
DUE TO (c): unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 7955

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] 0

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 DOA, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C W McKoskle M.D. 0
22b. ADDRESS: Caruthersville, Mo.
22c. DATE SIGNED: 4-30-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4-28-59
23c. NAME OF CEMETERY OR CREMATORY: Little Prairie
23d. LOCATION (City, town, or county) (State): Caruthersville, Mo.

24. FUNERAL DIRECTOR ADDRESS: La Forge Und. Co. Caruthersville Missouri
25. DATE RECD. BY LOCAL REG.: May 7, 1959
26. REGISTRAR'S SIGNATURE: Tressie R. Wilks

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAY 28 1959

CARUTHERSVILLE, MO.

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 Noel C Seale

Licensed Embalmer No. 3941

P. O. Address Caruthersville

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.