

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016611
STATE FILE NUMBER

FILED JUN 2 1959 Registration District No. 1 Primary Registration District No. 2000 Registrar's No. 161

300
1-57

1. PLACE OF DEATH a. COUNTY Adair			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Adair		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Novinger		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Grim-Smith Memorial Hosp.		Length of stay in 8 wks.	d. STREET ADDRESS Route 3		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Isaac Middle Francis Last Reese			4. DATE OF DEATH Month May Day 30 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1875	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months --- Days --- Hours --- Min. ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming	11. BIRTHPLACE (City and state or country) Novinger		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Peter Reese		13b. MOTHER'S MAIDEN NAME Sarah Shoop		14. NAME OF HUSBAND OR WIFE Sara G. Reese	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 498-40-3141	17. INFORMANT Address Mrs. Sara G. Reese, Novinger, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary thrombosis					
DUE TO (c) Arteriosclerotic coronary vascular disease					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Post suprapubic prostatectomy					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 --- Month, Day, Year --- a.m. --- p.m. ---					
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 5-3-59 to 5-20-59 and last saw ^{him} alive on 5-20-59 Death occurred at 8:25 am on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE P. E. Hilton (Name or title) P. E. Hilton, M. D.			22b. ADDRESS Kirksville, Mo.		22c. DATE SIGNED 5-21-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 22, 1959	23c. NAME OF CEMETERY OR CREMATORY Novinger Cemetery		23d. LOCATION (City, town, or county) Novinger, Mo. (State)	
24. FUNERAL DIRECTOR Glean E. Kent ADDRESS Green City, Mo.		25. DATE RECD. BY LOCAL REG. 5-23-1959	26. REGISTRAR'S SIGNATURE Doris W. Pattiff		

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

P. E. HILTON, M.D.

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 *Karl P. Kent*

Licensed Embalmer No. *4689*

P. O. Address: *Green City, 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.