

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 4 1960

=60-001838

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 364

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in 1b <u>17 yrs.</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>700 WEST 48th ST.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>700 WEST 48th STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alberta</u> Middle Last <u>Reed</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>19</u> Year <u>1960</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>APRIL 17, 1873</u>	9. AGE (last birthday) <u>86 YRS.</u>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Joseph, Mo.</u>			
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>JAMES STRAIN</u>		13b. MOTHER'S MAIDEN NAME <u>SALLY KERSEY</u>			
14. NAME OF HUSBAND OR WIFE <u>CLAY D. REED</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>NONE</u>			
17. INFORMANT <u>ALMA ROBASA 601 E. 74th TERR.</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>Coronary Insufficiency</u> DUE TO (b) <u>Coronary Sclerosis</u> Coronary thrombosis - healed Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>10 yrs</u> <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension - Acute Bronchitis</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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>10-5-57</u> to <u>1-19-60</u> and last saw her live on <u>1-18-60</u> . Death occurred at <u>8:30 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Decease or title) <u>Don Carlos Pesta md</u>			22b. ADDRESS <u>1500 Prof Bldg</u>		22c. DATE SIGNED <u>1-20-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1 21 60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAH CEM</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>D. W. NEWCOMER'S SONS K. C. MO.</u>			25. DATE RECD. BY LOCAL REG. <u>1-21-60</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Don Carlos Pesta

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____ Student-Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Roman W. Hansen

Licensed Embalmer No. 7589

P. O. Address T.C., 7/0

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.