# MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-029584
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4326

FILED SEP 13 1961

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Length of stay in 1b: 8 YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL — Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 2922 E. 28th — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First MELVIN Middle ALVERNON Last REED
4. DATE OF DEATH: Month AUGUST Day 28, Year 1961
5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2-19-11
9. AGE (last birthday): 50
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: McDowell Tire Co
11. BIRTHPLACE (City and state or country): Kansas City, Kansas
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Silas Reed
13b. MOTHER'S MAIDEN NAME: Mary Lumpkin
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): WWII
17. INFORMANT: VA HOSPITAL OFFICAL RECORDS, K. C. MO. Address

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) HODGKINS DISEASE — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
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. VA attended the deceased from 7-14-61 to 8-28-61 and last saw him alive on
Death occurred at 2 3:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE L E Denton (Degree or title) MD
22b. ADDRESS VA Hospital, K. C. Mo.
22c. DATE SIGNED 8-28-61

BY AFFIDAVIT OF S. E. Denton

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE 9-1-61
23c. NAME OF CEMETERY OR CREMATORY National Cemetery
23d. LOCATION (City, town, or county) (State) Ft. Leavenworth Kans
24. FUNERAL DIRECTOR N. W. Thatcher, K. C. Kans. ADDRESS
25. DATE REC'D BY LOCAL REG. 8-30-61
26. REGISTRAR'S SIGNATURE Ruth Long ~~N. W. Thatcher K.C.K.~~
(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

| ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED |
|---|---|---|---|
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**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 D. J. Manlove

Licensed Embalmer No. 3994

P. O. Address 3712 E 30th St

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.