

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041228
STATE FILE NUMBER

12755
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5502

FILED NOV 17 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 1 day	c. CITY OR TOWN Mission Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5317 Outlook Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) RICHARD VAUGHN REEVES	First Middle Last	4. DATE OF DEATH October 31, 1961	Month Day Year
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-30-1961	9. AGE (last birthday) 10-30-1961	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Randall D. Reeves	13b. MOTHER'S MAIDEN NAME Constance J. Foelgner	14. NAME OF HUSBAND OR WIFE - -
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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. None	17. INFORMANT Randall D. Reeves, 5317 Outlook, Mission	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory and circulatory failure	6 hrs -
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Massive adrenal hemorrhage	6 hrs -
	DUE TO (c) Prematurity (B.W. 3#12g)	1 day
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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 Lenexa, Johnson, Kansas	COUNTY STATE
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21. I attended the deceased from **10-30-61** to **10-31-61** and last saw him alive on **10-31-61**
Death occurred at **12:00** am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE W. Smull (Degree or title)	22b. ADDRESS 1501 Mission Road P.O. Box	22c. DATE SIGNED 10-31-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-31-1961	23c. NAME OF CEMETERY OR CREMATORY Resurrection	23d. LOCATION (City, town, or county) (State) Lenexa, Johnson, Kansas
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24. FUNERAL DIRECTOR Matt Skradski ADDRESS Skradski Funeral Home KCK	25. DATE RECD. BY LOCAL REG. 11-3-61	26. REGISTRAR'S SIGNATURE Ruth Long
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Mat Shredali

Licensed Embalmer No. 4382

P. O. Address K.C.S.

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.