

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-011284

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1514

STATE FILE NUMBER

FILED APR 2 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. P. Boughnau

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 50 YEARS	c. CITY OR TOWN KANSAS CITY 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) 644 WEST 61ST TERR. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES M. REED			4. DATE OF DEATH Month Day Year MARCH 14 1962
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/31/83
9. AGE (last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) JEFFERSON CITY, MO.
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME SAMUEL MOORE	
13b. MOTHER'S MAIDEN NAME BETTY		14. NAME OF HUSBAND OR WIFE W. HALEY REED	
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 Address MRS. ADAM COPELAND, DIXON, 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) CORONARY OCCLUSION DUE TO (b) CORONARY SCLEROSIS DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 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.)	
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 MARCH 13TH, 62 to March 14, 62 and last saw her alive on March 13, 1962 Death occurred at 8:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>H.P. Boughnau M.D.</i> (Degree or title)		22b. ADDRESS 226 PLAZA MEDICAL BLDG. 315 NICHOLS RD. K.C. MO.	22c. DATE SIGNED 3.15.62
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE MAR. 17, 1962	23c. NAME OF CEMETERY OR CREMATORY RIVERVIEW CEMETERY	23d. LOCATION (City, town, or county) JEFFERSON CITY MISSOURI
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS	ADDRESS 1331 BRUSH CR. KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 3-15-62	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

Dr. Henry Peter Bonphor
226 Ridge Medical Bldg - 315 Medical Park
11:30

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 Herold L. Betternacht

Licensed Embalmer No. 3035

P. O. Address Dr. C. C. Dawson

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.