

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001813

410 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

FILED FEB 6 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 35 yrs.	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 DeLora Rest Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2334 Jackson Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Harriet Alma Reed			4. DATE OF DEATH Month Day Year Jan. 20, 1963
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 4/24/1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self	9. AGE (last birthday) 79 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
11. BIRTHPLACE (City and state or country) Bolckow, Mo.		12. CITIZEN OF WHAT COUNTRY U S	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Clarence B. 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. _____	
17. INFORMANT Ward L. Reed		Address 4026 W. 72nd. Terr.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Arterioclerotic vascular disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Colon metastatic			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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SPICIDE <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 Dec 31, 1962 to 1/20/63 and last saw her ^{him} alive on 1-13-63 Death occurred at 147pm on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Underwood, M S</i> (Degree or title)		22b. ADDRESS 5100 E 24th K.C. Mo.	22c. DATE SIGNED 1/21/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/22/1963	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR Earp & Sons Mortuary Kansas City		25. DATE RECD. BY LOCAL REG. 1-22-63	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Underwood

SHOULD READ

INSTEAD OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

FORM 101 03/17

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

James W. Camp

Licensed Embalmer No. 4622

P. O. Address H. C., 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.