

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-044216  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 6002 Registrar's No. 5984

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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BY AFFIDAVIT OF

<b>1. PLACE OF DEATH</b> a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in this town <u>40 YEARS</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u> c. CITY OR TOWN <u>GASLAND</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>MARIE TURNER REED</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>NOVEMBER 2 - 1963</u>		
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-12-1874</u>	<b>9. AGE</b> (last birthday) <u>88 YEARS</u> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ALTERATIONS</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>DIAMOND CLOTHERS</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>SAN ANTONIA, TEXAS</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>
<b>13a. FATHER'S NAME</b> <u>UNKNOWN</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>JOHN REED (DECEASED)</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE.</u>	<b>17. INFORMANT</b> Address <u>J.C. NEWBY 606 WEST 52ND ST.</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Hypostatic Congestion</u> DUE TO (c) <u>Cerebral Hemorrhage</u> 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)					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
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of Item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year					
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		
<b>21. I attended the deceased from</b> <u>9-1-63</u> to <u>11-2-63</u> and last saw her/him alive on <u>11-2-63</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title) <u>W. Theel M.D.</u>			<b>22b. ADDRESS</b> <u>4301 Man St. KC Mo</u>	<b>22c. DATE SIGNED</b> <u>11-4-63</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>11-4-63</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>White Chapel Mem. Gardens, North Kansas city, Mo.</u>		<b>23d. LOCATION</b> (City, town, or county) (State)
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>MUENLEBACH 6800 TROOST</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>11-4-63</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Bessie Smith</u>	

USE BLACK INK OR TYPEWRITER RIBBON

By W. Theel

Dr. Otto Zell WEI-3199  
4301 MAIN 1:00 PM 5:30

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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 *A. E. Nichols*

Licensed Embalmer No. 4997

P. O. Address U. C. W.

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.