

FILED FEB 10 1943

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

1290

368

Registration District No. 109

Primary Registration District No. 1002

Registrar's No. ....

1. PLACE OF DEATH:  
(a) County JACKSON  
(b) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1020 PENN AVE.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community..... 10 MONTHS (Specify whether years, months or days)

3. (a) PRINT MRS. LUELLA LAVINA REED  
FULL NAME.

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife XXXXXX 6. (c) Age of husband or wife if alive XXXXXX years

7. Birth date of deceased 8 26 1857  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>85</u>	<u>4</u>	<u>27</u>	..... hr. .... min.

9. Birthplace GREENSBORO N. C.  
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business NONE

MOTHER FATHER { 12. Name ALEXANDER STARRETT  
13. Birthplace NO RECORD 9  
(City, town, or county) (State or foreign country)  
14. Maiden name NANCY GRAY  
15. Birthplace NO RECORD 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Reed  
(b) Address 1020 PENN. AVE.

17. (a) BURIAL (b) Date thereof 1 - 25 - 43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOUND GROVE

18. (a) Signature of funeral director [Signature]

(b) Address 815 W. MAPLE AVE. INDEPENDENCE, MO.

19. (a) 1-24-43 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County JACKSON  
(c) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1020 PENN. AVE.  
(If rural, give location)  
(e) Citizen of foreign country? NO. (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 23  
year 1943 hour 8 minute 00 A. M.

21. I hereby certify that I attended the deceased from Jan. 10, 1943, to Jan. 23, 1943;  
that I last saw her alive on Jan. 23, 1943,  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 5 Days

Due to Nephritis - Chronic about 1 year

Due to 131B

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations none

Of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?..... (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. (Specify type of place) (Means of injury)

Address Eugene Carbaugh M.D.  
1020 Penn. Ave. - Kansas City, Mo. Date signed 1-23-43

**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

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Henry W. Stahl*

Licensed Embalmer No.

*3181*

P. O. Address

*Independence*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**