V. S. No. 2
00M—2-43
ev. 5-17-39
I X35637

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 7 [redacted]

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17159

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2209

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: General Hospital #2 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4/18-5/8/43 (Specify whether In this community 40 Years or more years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County KJackson 48

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3

(d) Street No. 2523 Tracy (If rural, give location) 8

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Amanda Sheed

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female 9

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years 87? Months Days If less than one day hr. min.

9. Birthplace St. Charles County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name Louis Reed
13. Birthplace ? (City, town, or county) unknown ? (State or foreign country)

MOTHER
14. Maiden name Margaret ?
15. Birthplace ? (City, town, or county) unknown (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (Burial, [redacted]) (b) Date thereof 5-11-43 (Month) (Day) (Year)

(c) Place: burial or cremation Leeds

18. (a) Signature of funeral director W. A. Johnson

(b) Address City Mortuary

19. (a) 5-12-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8th year 1943 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from April 18, 1943, to May 8, 1943, that I last saw her alive on May 8, 1943, and that death occurred on the date and hour stated above.

Immediate cause of death Acute Congestive Heart Failure

Due to Hypertensive type Heart Disease.

Due to 93D

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. [redacted])

Address Gen. Hosp #2 Date signed 5/11/43

361 (Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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