

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED MAY 27 1946

Registration District No. _____ Primary Registration District No. 1002

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

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 No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 mins.
(Specify whether
 In this community 34 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Kansas (b) County Wyandotte
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 1125 Rowland Ave.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Harvey Reed
 3. (b) If veteran, name was unknown
 3. (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 10
 year 1946 hour 10 minute 55 P.M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Laura H. Reed
 6. (c) Age of husband or wife if alive 51 years
 7. Birth date of deceased April 4 1884
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 10, 1946 to 5-10, 1946.
 that I last saw alive on 5-10, 1946
 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>62</u>	<u>1</u>	<u>6</u>	hr. min.

Immediate cause of death
Occlusion left coronary with myocardial infarction
 Due to _____
 Due to _____

9. Birthplace Eudora Kansas
(City, town, or county) (State or foreign country)
 10. Usual occupation Electrical Operator
 11. Industry or business Board of Public Utilities
MOTHER FATHER
 { 12. Name Enos Reed
 { 13. Birthplace (Unknown) Ohio
(City, town, or county) (State or foreign country)
 { 14. Maiden name Louisa Walker
 { 15. Birthplace (Unknown) Iowa
(City, town, or county) (State or foreign country)

Other conditions 94a
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy See above
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Laura H Reed
 (b) Address 1125 Rowland
 17. (a) Burial (b) Date thereof May 13, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mount Hope Ceme.
 18. (a) Signature of funeral director Geo. H. Long
 (b) Address 703 North Tenth Street
 19. (a) 5-13-46 (b) Steraldine Holman
(Date received local registrar) (Registrar's signature)

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?
 While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature Wm W Hart (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp. Date signed 5-11-46

Dr. Miller

25811-1-14

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..... *Chas. H. Rider*
Licensed Embalmer No. *3404*
P. O. Address *703 N. 10th St. K.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 this body is not embalmed, fact should be so stated above.