

S. No. 2
DM-5-43
v. 5-17-39
I X36671

FILED MAY 29 1947
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: St. Lukes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days
(Specify whether years, months or days) Lifetime

3. (a) PRINT FULL NAME CHARLES A. REED

3. (b) If veteran, name war None

3. (c) Social Security No. 708-18-4323

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Mrs. Edith Reed

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased December 26 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

63 4 20 hr. min.

9a. Birthplace Kansas City, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Representative

11. Industry or business Belt R. Co. of Chicago

MOTHER, FATHER

12. Name Jayne J. Reed

13. Birthplace Lorense, Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Cynthia Ann Walker

15. Birthplace Monticello, Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Edith Reed

(b) Address 4019 Chestnut Ave., K.C.Mo.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof May 19 1947
(Month) (Day) (Year)

(c) Place: burial or cremation D. H. Myers Sons

18. (a) Signature of funeral director D. H. Myers Sons

(b) Address 1401 Brush Creek Blvd. K.C.Mo.

19. (a) 5-19-47 (Date received local registrar) St. Pauline Holmes (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. 4019 Chestnut Avenue
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16 year 1947 hour 17 minute 30 M.

21. I hereby certify that I attended the deceased from 5-12 1947, to 5-16 1947 that I last saw him alive on 5-15 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Right coronary artery occlusion (acute)

Duration 3 days

Due to Arteriosclerotic heart disease with cardiac decompensation 1 yr.

Due to _____

Other conditions Pulmonary edema at lung base none of depth

Major findings: Of operations _____

Of autopsy as above. 93 d

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature D. Donald H. Ireland (M. D. or other) M.D.

Address 315 Alameda Road K.C. Mo. Date signed 5-17-47

Page must be signed

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 *Bernard J. Horan*.....

Licensed Embalmer No. *4250*.....

P. O. Address *K C M J*.....

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.