S. No. 2
4—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

38378
State File No.

FILED DEC 9 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4948

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 Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 5 months (Specify whether years, months or days)

In this community: 10 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

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

(d) Street No.: 3118 E. 11th 6
(If rural, give location)

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

If yes, name country: 0

3. (a) PRINT FULL NAME: FLORENCE LUCILLE REED

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: Fe. 1

5. Color or race: white

6. (a) Single, widowed, married, divorced: 0 single

6. (b) Name of husband or wife:

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

7. Birth date of deceased: April 20 1913 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
34	7	4	hr. min.

9. Birthplace: Warrensburg (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation: School Teacher

11. Industry or business: Merriam Grammar School

FATHER
12. Name: G.N. Reed

13. Birthplace: LaMonte Mo (City, town, or county) (State or foreign country) 0

MOTHER
14. Maiden name: Maude Ferguson

15. Birthplace: Warrensburg Mo (City, town, or county) (State or foreign country) 0

16. (a) Informant: G.N. Reed

(b) Address: 4816 Charlotte

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 11-26-1947 (Month) (Day) (Year)

(c) Place: burial or cremation: Knobnoster Mo

18. (a) Signature of funeral director: C.H. Blackman & Son, Inc.

(b) Address: 2825 Independence Blvd.

19. (a) 11-25-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov. day: 24 year: 1947 hour: 10 minute: 15A M.

21. I hereby certify that I attended the deceased from March 15, 1947, to Nov. 24, 1947, that I last saw her alive on Nov. 24, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Circulatory Failure	about 12 hrs.
Due to: Insanition	2 mos.
Anemia	6 mos.
Due to: Melanocarcinoma with multiple metastases	9 years

Other conditions: (Include pregnancy within 3 months of death) 552 primary in left calf

Major findings:
Of operations:
Of autops: Melanocarcinoma & metastasis Lung; Brain; Liver; Bowel; Skin.

PHYSICIAN — Underline the cause of 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: 0

23. Signature: Harold M. Roberts (M. D. or other) M.D.

Address: 1103 Grand, K.C., Mo. Date signed: 11-25-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Dr. Harold Roberts
Prof. Bldg
after 2 Ha 1331

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 H D Blackman

Licensed Embalmer No. 3639

P. O. Address 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.