

STANDARD CERTIFICATE OF DEATH

33256

State File No.

FILED NOV 13 1951

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 952

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Christian	
b. CITY (If outside corporate limits, write FULL and give township) Springfield		c. LENGTH OF STAY (in this place) 4 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION OSZARK OSTEOPATHIC HOSPITAL		B. STREET ADDRESS (If rural, give location) Sparta, SStar Rt. Mo	
3. NAME OF DECEASED (Type or Print) a. (First) HARVEY		b. (Middle) —	
c. (Last) REED		4. DATE OF DEATH (Month) (Day) (Year) 11-7-51	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan. 2. 1898	
9. AGE (In years last birthday) 53		IF UNDER 1 YEAR: Months _____ Days _____	
IF UNDER 10 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (State or foreign country) Mo	
12. CITIZEN OF WHAT COUNTRY? U S A		13a. FATHER'S NAME Lige Reed	
13b. MOTHER'S MAIDEN NAME Emma Canon		14. NAME OF HUSBAND OR WIFE Grace Reed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT'S SIGNATURE OR NAME Harley Reed		ADDRESS Sparta. Mo	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Circulatory Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary thrombosis and Myocardial infarction DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11-3- , 19 51 , to 11-7 , 19 51 , that I last saw the deceased alive on 11-7 , 19 51 , and that death occurred at 5:05 Am. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Deland C. ...		23b. ADDRESS Springfield, Mo.	
23c. DATE SIGNED 11/7/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 12. 1951	
24c. NAME OF CEMETERY OR CREMATORY Bruner		24d. LOCATION (City, town, or county) (State) Christian Mo	
DATE REC'D BY LOCAL REG. 11-9-51		REGISTRAR'S SIGNATURE T. E. Handley	
25. FUNERAL DIRECTOR'S SIGNATURE T. B. Chaffin		ADDRESS Ozark, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 15 1959

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed F. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Clark, 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.