

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 3 - 1953

BIRTH NO.		REG. DIST. NO. 360		PRIMARY REG. DIST. NO. 6225		Registrar's No. 51	
1. PLACE OF DEATH a. COUNTY Vernon				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) Vernon Washington Mo 46-28-50		c. LENGTH OF STAY (in this place) 46-28-50		c. CITY (If outside corporate limits, write RURAL and give township) St Charles Mo 3928		d. STREET ADDRESS (If rural, give location) 8912 Ward Parkway	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital #3				d. STREET ADDRESS (If rural, give location) 8912 Ward Parkway			
3. NAME OF DECEASED (Type or Print) NATILDA REED		a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH 2-27-53		5. SEX F		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	
8. DATE OF BIRTH unknown		9. AGE (In years last birthday) 58		IF UNDER 1 YEAR Months 4 Days 11		IF UNDER 24 HRS. Hours 11 Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) Mo		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Albert C Reed			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. V		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hospital record			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute myocardial infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Dementia Praecox DUE TO (c) V				INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. V		3007					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-31-1947 , to 2-27-1953 , that I last saw the deceased alive on 2-27-1953 , and that death occurred at 10-15-53 from the causes and on the date stated above.							
23a. SIGNATURE R. G. Hall MD (Degree or title)				23b. ADDRESS Nevada Mo		23c. DATE SIGNED 2-27-53	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Mar. 3-1953		24c. NAME OF CEMETERY OR CREMATORY Floral Hills		24d. LOCATION (City, town, or county) (State) Kansas City Mo	
DATE REC'D BY LOCAL REG. 2-27-53		REGISTRAR'S SIGNATURE Anna E. Ferry		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Floral Hills Memorial Chapel K.C., Mo			

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

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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 William E. Free

Licensed Embalmer No. 4733

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.