

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28343

State File No. ....

FILED SEP 8 - 1953

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>821</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Springfield</u>		c. LENGTH OF STAY (in this place) <u>2 Days</u>		c. CITY OR TOWN <u>Springfield</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Burge Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>2326 N. Kellett</u> <span style="float: right;"><u>0396</u></span>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>LUTHER</u>		b. (Middle) <u>V.</u>		c. (Last) <u>REED</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 28 1953</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>28 Jan. 1889</u>	
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 MRS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Charles H. Reed</u>			13b. MOTHER'S MAIDEN NAME <u>Millie Weaver</u>			14. NAME OF HUSBAND OR WIFE <u>Not Married</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Alma Rippee</u>		ADDRESS <u>Springfield, Mo.</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiovascular renal disease</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: <u>Hypertension, Atrial fibrillation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>442X</u>				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) <u>Springfield, Mo.</u>			
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 <u>8-26</u> <sup>1953</sup> to <u>8-28</u> , 1953, that I last saw the deceased alive on <u>8-28</u> , 1953, and that death occurred at <u>7:10P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Walter Williams M.D.</u> (Degree or title)				23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>8-29-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-30-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Prospect Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Webster County Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-31-53</u>		REGISTRAR'S SIGNATURE <u>Walter Williams</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.W. KLINGNER &amp; CO. Springfield, Mo.</u>			

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

**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.....  
Signature of Student Embalmer

Signed..... *Max R. [Signature]*

Licensed Embalmer No. .... *40*

P. O. Address..... *[Signature]*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.