

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **28824**  
Registrar's No. **4094**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, write RURAL and give township): OR TOWN <b>Kansas City</b>		c. LENGTH OF STAY (in this place) <b>47-48</b>	c. CITY OR TOWN <b>Kansas City</b>		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 <b>General Hospital No. 1</b>			e. STREET ADDRESS (If rural, give location) <b>19 4410 E. 10</b>	<b>3198</b>	
3. NAME OF DECEASED (Type or Print) <b>Pearl</b>			a. (First)	b. (Middle)	c. (Last) <b>Reed</b>
4. DATE OF DEATH (Month) (Day) (Year) <b>8 17 1953</b>		5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow 2</b>	8. DATE OF BIRTH <b>April 17, 1885</b>
9. AGE (In years last birthday) <b>68</b>		IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister Of Gospel</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Illinois /</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13a. FATHER'S NAME <b>Nathaniel Grant Stewart</b>	13b. MOTHER'S MAIDEN NAME <b>Lovina Castille</b>	14. NAME OF HUSBAND OR WIFE <b>Grant Reed</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Garrie Woods 2002 West 48st K.C. Kansas</b>		
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) <b>Carcinoma of cervix</b>  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.			INTERVAL BETWEEN ONSET AND DEATH  <b>171*</b>
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) m.		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 <b>May 6</b> , 19 <b>53</b> , to <b>August 17, 1953</b> , that I last saw the deceased alive on <b>August 17, 1953</b> , and that death occurred at <b>1 A.</b> m., from the causes and on the date stated above.					
23a. SIGNATURE <b>B.I. Burns</b> (Degree or title) <b>B.I. Burns, M.D.</b>			23b. ADDRESS <b>24th &amp; Cherry</b>		23c. DATE SIGNED <b>8-17-53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8-19, 1953.</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Florial Hills</b>	24d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>	
DATE REC'D BY LOCAL REG. <b>8-18-53</b>		REGISTRAR'S SIGNATURE <b>Steldine Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Mrs. C.L. Forster Kansas City Mo.</b>	

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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 359

P. O. Address.....

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.