

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43125

5867

FILED DEC 29 1953
BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission). a. STATE Kansas b. COUNTY Johnson	
b. CITY OR TOWN Kansas City <small>(If outside corporate limits, write RURAL and give township)</small>		c. CITY OR TOWN Mission	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 10 months		e. STREET ADDRESS (If rural, give location) 7527 Mohawk Drive	
d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Hospital		8150 S	
3. NAME OF DECEASED (Type or Print) a. (First) C. b. (Middle) VICTOR c. (Last) REED		4. DATE OF DEATH (Month) (Day) (Year) Dec. 14, 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 10, 1875
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days	IF OVER 1 YR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Finisher		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Sweden
12. CITIZENSHIP OF WHAT COUNTRY? USA		13a. FATHER'S NAME Andrew J. Reed	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mrs. Alba Reed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 071-10-4160A	
17. INFORMANT'S SIGNATURE OR NAME Walter L. Reed, 7527 Mohawk Drive.		ADDRESS	
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) Perforated Ulcer 4 hrs ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ulcer - 4 hrs chronic DUE TO (c) Emaciation II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Gen. Ant. Sclerosis	
INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs		Yrs. 4	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) 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 10 DEC, 19 53 to 14 DEC, 19 53 that I last saw the deceased alive on 13 DEC, 19 53 and that death occurred at _____ m., from the causes and on the date stated above.	
23a. SIGNATURE Robert M. Myers (Degree or title)		23b. ADDRESS 1025 Beale Bldg	
23c. DATE SIGNED 14 DEC 53		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 12-15-53		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State) Jamestown, New York		25. FUNERAL DIRECTOR'S SIGNATURE Freeman Mortuary ADDRESS Kansas City, Missouri	
DATE REC'D BY LOCAL REG. 12-14-53		REGISTRAR'S SIGNATURE Sheldine Smith	

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

