

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 15 1954

State File No. 753

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 Missouri b. COUNTY Carroll			
b. CITY OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 1 day		c. CITY OR TOWN Carrollton		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. Research Hospital				e. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) CARL		a. (First)		b. (Middle)		c. (Last) REED	
4. DATE OF DEATH Feb. 17, 1954		4. DATE (Month) (Day) (Year)					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH June 21, 1889	
9. AGE (In years last birthday) 64		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) Eldora, Iowa /	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME George R. Reed		13b. MOTHER'S MAIDEN NAME --- Haley		14. NAME OF HUSBAND OR WIFE Oattie May 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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS John Wm. Reed, 9005 E. 73, Raytown, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Embolism				RELATED		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
ANTECEDENT CAUSES				DUE TO (b) Acute Myocardial Infarction		3 days	
DUE TO (c) Coronary Artery Sclerosis						6 mo -	
II. OTHER SIGNIFICANT CONDITIONS				Arterial Hypertension		2 year	
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, 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 Jan 10, 1952, to Feb 17, 1954, that I last saw the deceased alive on Feb 17, 1954, and that death occurred at 8:20 PM from the causes and on the date stated above.							
23a. SIGNATURE Graham Asher (Degree or title) MD				23b. ADDRESS 1220 Professional Bldg, Kansas City 6 - Mo.		23c. DATE SIGNED 2-17-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-17-54		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Carrollton, Missouri	
DATE REC'D BY LOCAL REG. 2-17-54		REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE UND. CO.		ADDRESS K.C. MO.	

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

Mr. H. H. ...
1250 ...
V. 8188

17029

EXPIRES ...

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 *Gerald A. Burger*

Licensed Embalmer No. 476

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