

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30323

State File No. 863

FILED SEP 20 1954

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (In this place) 5 days	c. CITY OR TOWN Springfield Missouri
d. FULL NAME OF HOSPITAL OR INSTITUTION Trotter Nursing Residence		e. STREET ADDRESS (If rural, give location) 615 North Main Avenue	

3. NAME OF DECEASED (Type or Print)	a. (First) EMORY	b. (Middle) (Unknown)	c. (Last) REID	4. DATE OF DEATH (Month) (Day) (Year) Sept. 14, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 1897	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (City and State or Foreign Country) Unknown	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Trotter Nursing Residence Spgfd, Mo.	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor. Myocarditis		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 9-12-1954 to 9-13-1954 that I last saw the deceased alive on 9-13-1954 and that death occurred at 4:30 a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph P. Hills M.D.	23b. ADDRESS Springfield, Missouri	23c. DATE SIGNED 9/14/1954
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9/14/1954	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Waynesville, Missouri
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DATE REC'D BY LOCAL REG. 9-17-54	REGISTRAR'S SIGNATURE Frank Williamson	25. FUNERAL DIRECTOR'S SIGNATURE Harry C. Cline	ADDRESS Springfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

623 West Walnut

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....45

P. O. Address ..Springfield

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.