

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34100**
Registrar's No. **4889**

FILED NOV 10 1954

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>4889</u>		
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, write RURAL and give town or township) Kansas City		c. LENGTH OF STAY (in this place) 40 yrs		c. CITY OR TOWN Kansas City		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 General Hospital No. 1				STREET ADDRESS (If rural, give location) 2849 E. 7 3188				
3. NAME OF DECEASED (Type or Print) a. (First) Hugh b. (Middle) Kavanaugh c. (Last) Rea			4. DATE OF DEATH (Month) (Day) (Year) 10 21 1954					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec 20 1870		
				9. AGE (in years last birthday) 83		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) Carrollton, Mo.		
12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME Glayland Rea		13b. MOTHER'S MAIDEN NAME Patricia Brooks		14. NAME OF HUSBAND OR WIFE Lula Rea	
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. 491-22-3811		17. INFORMANT'S SIGNATURE OR NAME Lula Rea ADDRESS Kansas City, Mo.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary embolism 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 Subtrochanteric fracture of left femur Intertrochanteric fracture right femur					INTERVAL BETWEEN ONSET AND DEATH E9020 21	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Above address		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) Kansas City, Jackson, Missouri		21d. (ESTATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10 8 1954 A.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell out of chair				
22. I hereby certify that I attended the deceased from <u>Oct. 8</u> , 19 <u>54</u> , to <u>Oct. 21</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Oct. 21</u> , 19 <u>54</u> , and that death occurred at <u>6:40A m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE B.I. Burns (Degree or title) D.				23b. ADDRESS 24th & Cherry		23c. DATE SIGNED 10-21-54		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 21 1954		24c. NAME OF CEMETERY OR CREMATORY Oak Hill		24d. LOCATION (City, town, or county) (State) Carrollton, Mo.		
DATE REC'D BY LOCAL REG. 10-21-54		REGISTRAR'S SIGNATURE Neva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs CL. Forster Funeral Home K.C. Mo.				

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 *Dean Owens*.....

Licensed Embalmer No. *428*.....

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.