

FILED AUG 3-1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22340

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3079

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) <b>Kansas City</b>	c. LENGTH OF STAY (in this place) <b>40 yrs.</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>Trinity Lutheran Hospital</b>		STREET ADDRESS (If rural, give location) <b>4520 Salem Court</b>	

3. NAME OF DECEASED (Type or Print) <b>WARREN</b>	a. (First) <b>WARREN</b>	b. (Middle) <b>C.</b>	c. (Last) <b>REED</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 18, 1955</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Dec. 25, 1901</b>	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) <b>53</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Advertising Representative-Publications</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Amity, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Robert Reed</b>	13b. MOTHER'S MAIDEN NAME <b>Nettie Hade</b>	14. NAME OF HUSBAND OR WIFE <b>Jean N. Reed</b>
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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) <b>yes S.A.T.C.</b>	16. SOCIAL SECURITY NO. <b>493-22-3176</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Jean Reed, 4520 Salem Court, K.C.Mo.</b>	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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <b>4200</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>congestive heart failure</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerotic heart disease</b>		
	DUE TO (c) <b>unknown</b>		
	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 checked="" type="checkbox"/> NO <input 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 \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>Robert G. Vernon, M.D.</b>	23b. ADDRESS <b>30 x Weyandotte K.C.Mo</b>	23c. DATE SIGNED <b>7/19/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-20-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah</b>	24d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>7-19-55</b>	REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>STINE &amp; McCLURE UND. CO.</b>	ADDRESS <b>K.C.MO.</b>
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WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

AUG 4 1954

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 *Elmer D. Fiplett*.....

Licensed Embalmer No. *481*

P. O. Address *San Francisco*

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.