THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1009
STATE FILE NUMBER

FILED JAN 21 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 53

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2041 N. Prospect — Length of stay in Hospital 47 Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 2041 N. Prospect — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First GEORGE Middle O. Last REED

4. DATE OF DEATH Month Jan. Day 14, 1957

5. SEX Male 6. COLOR OR RACE White 7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 24 Dec. 1867

9. AGE (In years last birthday) 89 — 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) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Reed
14. MOTHER'S MAIDEN NAME Elizabeth Roller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Clell Reed Address Springfield, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH 1 yr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4200
19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 1954, to Jan 1957 and last saw her/him alive on 1-14-57
Death occurred at 11:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE A. M. Klingner (Degree or title) M.D.
22b. ADDRESS 1630 N. Jefferson Springfield, Missouri
22c. DATE SIGNED 1-15-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1-16-57
23c. NAME OF CEMETERY OR CREMATORY White Chapel
23d. LOCATION (City, town, or county) (State) Springfield, Mo.

24. FUNERAL DIRECTOR J. W. Klingner & Co.
ADDRESS Spgfd. Mo.
25. DATE RECD. BY LOCAL REG. 1-16-57
26. REGISTRAR'S SIGNATURE Estella Williamson

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be accepted. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Glen D. Williams

Licensed Embalmer No. 46

P. O. Address Springfi

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.