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FILED MAR 3 - 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-005799

STATE FILE NUMBER 704

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) DR LORA RESTA WHITE 622 BENTON BLVD. — Length of stay in Ib 40 YEARS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 1030 BENTON BLVD. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First ANGIE Middle E Last REID

4. DATE OF DEATH: Month FEBRUARY Day 9 Year 1958

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: JAN. 1. 1875
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): RETIRED TEACHER
10b. KIND OF BUSINESS OR INDUSTRY: SCHOOL
11. BIRTHPLACE (City and state or country): PARIS, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: WILLIAM S. REID
13b. MOTHER'S MAIDEN NAME: LAURA M. BUFORD
14. NAME OF HUSBAND OR WIFE: --

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS. S. L. THOMPSON Address: DENVER COLORADO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Senility
DUE TO (c)
331 K

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] 0

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 4 yrs. ago, to 2-9-58 and last saw her/him alive on 2-9-58
Death occurred at 11:25 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Calvin A. Beard (Degree or title) MD 0 — 22b. ADDRESS 2307 Bryant Bldg — 22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL — 23b. DATE FEB-11-1958 — 23c. NAME OF CEMETERY OR ~~CREMATORY~~ WALNUT GROVE CEMETERY — 23d. LOCATION (City, town, or county) PARIS (State) MISSOURI

24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS. ADDRESS 1331 BRUSH CREEK KANSAS City, Mo. — 25. DATE RECD. BY LOCAL REG. 2-10-58 — 26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Calvin A. Beard

Aug. 1, 1924

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 Norman W. Thorson

Licensed Embalmer No. 4889

P. O. Address N. 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.