

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-017314  
STATE FILE NUMBER

FILE MAY 26 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 230

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JASPAR</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Joplin</u> 04950
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Center Medical</u>		Length of stay in 1b <u>7 1/2 hrs.</u>	d. STREET ADDRESS (If outside, give location) <u>Gateway Hotel</u>
3. NAME OF DECEASED (Type or print) First <u>Sherwood</u> Middle Last <u>Reed</u>			4. DATE OF DEATH Month <u>5</u> Day <u>16</u> Year <u>58</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>UNKNOWN</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	9. AGE (In years last birthday) <u>47 1/2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	11. BIRTHPLACE (City and state or country) <u>9</u>
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <u>unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT <u>Patient hospital chart</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Bleeding Esophageal Varices</u>			<u>36 hours?</u>
DUE TO (c) <u>Laennec's cirrhosis</u>			<u>5811</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Aspiration pneumonia; questionable narcotic addiction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
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 <u>5/16/58</u> to <u>5/16/58</u> and last saw him alive on <u>5/16/58</u> Death occurred at <u>8:30 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Frank T. Mohs, M.D.</u> (Degree or title)		22b. ADDRESS <u>U. of Missouri Med Center; Columbia, Mo.</u>	
22c. DATE SIGNED <u>5/17/58</u>		22d. DATE SIGNED	
23a. CREMATION, <input checked="" type="checkbox"/> (Specify)	23b. DATE <u>5-22-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>anatomical board</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia MO</u>
24. FUNERAL DIRECTOR <u>J. O. Roberts Columbia MO</u>		25. DATE RECD. BY LOCAL REG. <u>May 22 1958</u>	26. REGISTRAR'S SIGNATURE <u>Miss R E Palmer</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *J. B. Roberto* .....

~~Licensed Embalmer No.~~ .....

P. O. Address .....

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.