

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006327
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 52

300
1-57 C

1. PLACE OF DEATH a. COUNTY <i>LIVINGSTON</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>LIVINGSTON</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Chillicothe</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Chula.</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Chillicothe Hospital</i>		Length of stay in 1b <i>3 Days</i>	d. STREET ADDRESS (If outside, give location) <i>4 MI. S.E. Chula</i>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Frank C Reid</i>			4. DATE OF DEATH Month Day Year <i>February 10 1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>February 19 1876</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (City and state or country) <i>New Carlisle Ind</i>
13a. FATHER'S NAME <i>Lafayette Reid</i>		13b. MOTHER'S MAIDEN NAME <i>Addie Sparrow</i>	14. NAME OF HUSBAND OR WIFE <i>Lillie Reid</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT Address <i>Dick Reid Chula Mo</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peritonitis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Gangrene of intestines</i>			<i>3 days</i>
DUE TO (c) <i>Strangulated Umbilical Hernia</i>			<i>4 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Coronary Heart Failure.</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <i>Feb. 19 1959</i> to <i>Feb. 10 1959</i> and last saw ^{her} _{him} alive on <i>Feb. 10, 1959</i> Death occurred at <i>7:45</i> ^{A.} m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>William Bryan D.O.</i>		(Degree or title)	22b. ADDRESS <i>Wheeling, Mo.</i>
22c. DATE SIGNED <i>2-10-59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>February 12 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Plumvious Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Chula Missouri</i>
24. FUNERAL DIRECTOR <i>E. J. Robertson Funeral Home</i>		ADDRESS <i>Chula Mo</i>	25. DATE RECD. BY LOCAL REG. <i>2-10-59</i>
		26. REGISTRAR'S SIGNATURE <i>Frances B Neill</i>	

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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. Robertson*

Licensed Embalmer No. *4388*
P. O. Address *Laredo, Tex.*

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.