

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008621
STATE FILE NUMBER

FILED APR 9 1959 Registration District No. 389 Primary Registration District No. 5193 Registrar's No. 3

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Calloway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Calloway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Holtsummit</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Holtsummit</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	0448 STREET ADDRESS (If outside, give location) <u>0</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Olivia</u> Middle <u>Pearl</u> Last <u>Reed</u>			4. DATE OF DEATH Month <u>Mar</u> Day <u>30</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>69</u> F UNDER 1 YEAR Months <u>2</u> Days <u>29</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>WINN Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13a. FATHER'S NAME <u>Thomas Wilson</u>		13b. MOTHER'S MAIDEN NAME <u>Madie Wilson</u>	
14. NAME OF HUSBAND OR WIFE <u>James Reed.</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Mrs Margaret Hughes Holtsummit Mo</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>Coronary Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>fatal Arterio Sclerosis</u> DUE TO (c) <u>4201</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>			
20d. INJURY OCCURRED WHILE AT <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>Mar 1-1959</u> to <u>Mar 30-59</u> and last saw her alive on <u>Mar 1-1959</u> Death occurred at <u>12:45</u> P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. M. Rust M.D.</u> (Degree or title)		22b. ADDRESS <u>New Bloomfield Mo</u>	
22c. DATE SIGNED <u>Mar 31-1959</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>APR 12-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Holtsummit Mo.</u>
24. FUNERAL DIRECTOR <u>Claypool Service</u>		ADDRESS <u>New Bloomfield</u>	25. DATE RECD. BY LOCAL REG. <u>3-31-59</u>
26. REGISTRAR'S SIGNATURE <u>LeRoy Claypool</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc.: must state why standard nomenclature is being used: no symptoms were observed. All diseases in Part I must be causally related.

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 *LeRoy Clayton*

Licensed Embalmer No. *4412*
P. O. Address. *New Bloomfield, Pa.*

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.