

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013508

FILED MAY 13 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2002

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1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hosp.		Length of stay in lb 56 yrs.	d. STREET ADDRESS (If outside, give location) 3928 Woodland
3. NAME OF DECEASED (Type or print) First JOHN Middle T. Last REID			4. DATE OF DEATH Month April Day 20 Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	11. BIRTHPLACE (City and state or country) Milen, Mo.
13a. FATHER'S NAME J. T. Reid		13b. MOTHER'S MAIDEN NAME Laura Melia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 487-05-5455	17. INFORMANT Address Louis Ochiskey 3732 Indiana
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 6 yrs
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 3/11/52 and last saw her alive on 4/20/59 Death occurred at 12/25/59 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature] (Degree or title) M.D.		22b. ADDRESS Professional Bldg, - K.C., Mo	22c. DATE SIGNED 4-20-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-22-59	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR ADDRESS Mellody-McGilley-Eylar 1800 Linwood		25. DATE RECD. BY LOCAL REG. 4-21-59	26. REGISTRAR'S SIGNATURE [Signature]

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

C. G. Leitch

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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 *Melvin Bastian*

Licensed Embalmer No. *4903*
P. O. Address *K 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.