

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023923

STATE FILE NUMBER

108

FILED JUN 30 1959 Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 108

1. PLACE OF DEATH a. COUNTY <i>Vermon County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Vermon</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Washington Township</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>Nevada, Mo.</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT IN HOSPITAL, give location) HOSPITAL OR INSTITUTION <i>State Hospital No. 3</i> Length of stay in lb <i>2 yrs 7 mos 6 days</i>		d. STREET ADDRESS (If outside, give location) <i>1204 N. Cedar St</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>CECIL COLUMBUS REED</i>			4. DATE OF DEATH Month Day Year <i>6 20 1959</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-14-1903</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroad Switchman</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Mo. RR. retired</i>	9c. AGE (In years last birthday) <i>55</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroad Switchman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Mo. RR. retired</i>	10c. BIRTHPLACE (City and state or country) <i>Nevada Mo.</i>
11. BIRTHPLACE (City and state or country) <i>Nevada Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>James Reed</i>		13b. MOTHER'S MAIDEN NAME <i>Margaret Pruitt</i>	
14. NAME OF HUSBAND OR WIFE <i>Myrtle Reed</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>never</i>		16. SOCIAL SECURITY NO. <i>702-18-1167</i>	17. INFORMANT <i>Hospital record</i> Address
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>coronary thrombosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>arteriosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>4201</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Two days</i>
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 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>12/31/1956</i> to <i>6/20/1959</i> and last saw ^{her} alive on <i>6/20/1959</i> Death occurred at <i>2:10 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>George Esker M.D.</i> (Name or title)		22b. ADDRESS <i>State Hospital No. 3 Nevada, Mo.</i>	22c. DATE SIGNED <i>6/20/1959</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>6-23-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Desperand Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Nevada, Missouri</i>
24. FUNERAL DIRECTOR <i>Ermy Funeral Home, Nevada, Mo.</i> ADDRESS		25. DATE RECD. BY LOCAL REG. <i>6-24-1959</i>	26. REGISTRAR'S SIGNATURE <i>Anna & Jerry</i>

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 *L. Anglin Ferry*

Licensed Embalmer No. *4960*

P. O. Address. *Henrieville, 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.