

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 6 1959

59-036649

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 204

STATE FILE NUMBER

ENDED

| | | | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|---|------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Jasper | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage | | | Length of stay in 1b 5 1/2 days | | c. CITY OR TOWN Morrow | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks hosp. | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) --- | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First DONALD Middle ADAIR Last REED | | | | | | 4. DATE OF DEATH Month October Day 26 , Year 1959 | | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 6-17-1932 | | 9. AGE (last birthday) 27 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) trucker | | | 10b. KIND OF BUSINESS OR INDUSTRY trucking | | 11. BIRTHPLACE (City and state or country) Morrow, Arkansas | | 12. CITIZEN OF WHAT COUNTRY USA | | | | |
| 13a. FATHER'S NAME Troy Reed | | | | 13b. MOTHER'S MAIDEN NAME Marie Latta | | | 14. NAME OF HUSBAND OR WIFE Irmalee Rinehart Reed | | | | |
| 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. not available | | 17. INFORMANT Address Irmalee Reed, Morrow, Ark | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LACERATION BRAIN | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | | | |
| 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) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input checked="" 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.) TWO TRUCK ACCIDENT | | | | | | | |
| 20c. TIME OF INJURY Hour 3:45 a.m. xxx | | Month, Day, Year 10-21-59 | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) Highway 71 | | 20f. CITY, TOWN, OR LOCATION Jasper | | COUNTY JASPER | | STATE MO | | | |
| 21. I attended the deceased from 10-21-59 to 10-26-59 and last saw her/him alive on 10-26-59 Death occurred at 8 p m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Frank H. Brimmer MD | | | | | | 22b. ADDRESS Carthage, Mo | | | 22c. DATE SIGNED 10-26-59 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 10-27-59 | | 23c. NAME OF CEMETERY OR CREMATORY Bethesda Cemetery | | | 23d. LOCATION (City, town, or county) (State) Morrow, Arkansas | | | | |
| 24. FUNERAL DIRECTOR ADDRESS Knell Mortuary, Carthage, Mo | | | | 25. DATE RECD. BY LOCAL REG. 10-27-59 | | 26. REGISTRAR'S SIGNATURE W. E. Clinton | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 1 1959

DEC 1 2 1959

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 ^x Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address Carthage, 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.