

FEDERAL BUREAU OF INVESTIGATION
FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 30 1959 278

59-041285

STATE FILE NUMBER

Registration District No. Primary Registration District No. 3054 Registrar's No. 137.

RECEIVED

1. PLACE OF DEATH a. COUNTY PIKE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY PIKE			
b. CITY (If outside corporate limits, give TOWNSHIP only) LOUISIANA		Length of stay in 1b 24 YRS		c. CITY OR TOWN LOUISIANA		Inside Limits Yes ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) 1101 S. CAROLINA ST.		Inside Limits Yes ☒ No ☐		d. STREET ADDRESS (If outside, give location) 1101 S. CAROLINA ST.		Reside on Farm Yes ☐ No ☒	
3. NAME OF DECEASED (Type or print) First Middle Last IOAN REED				4. DATE OF DEATH Month Day Year NOV 16 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐		8. DATE OF BIRTH 8-5-1866	
9. AGE (last birthday) 93		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life or last period) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (City and state or country) LOUISIANA MO.		12. CITIZEN OF WHAT COUNTRY USA.	
13a. FATHER'S NAME GRIFFITH		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE JOHN WILLIAM 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. NO		17. INFORMANT Address MRS GORDON HUNEKE St Louis Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident Interval between ONSET and DEATH 12 hrs DUE TO (b) Arteriosclerotic Hypertensive Cardio vascular renal disease Interval between ONSET and DEATH 10 yrs Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ---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. ☐ Yes ☐ No ☐ Unknown							
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒		20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		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 10/22/56 to 11/16/59 and last saw her alive on 11/16/59 Death occurred at 700 A m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Chas A. Lewellen (Degree or title) M.D.				22b. ADDRESS Louisiana, Missouri		22c. DATE SIGNED 11/18/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE NOV 18-1959		23c. NAME OF CEMETERY OR CREMATORY RIVER VIEW		23d. LOCATION (City, town, or county) (State) LOUISIANA MO.	
24. FUNERAL DIRECTOR Collier FUNERAL SERVICE		ADDRESS LOUISIANA MO.		25. DATE RECD. BY LOCAL REG. Nov 18, 1959		25. REGISTRAR'S SIGNATURE Bernice Collier	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.