

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-006729**

**FILED VS FEB 25 1960**

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 106

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		Length of stay in 1b <b>3 days</b>	c. CITY OR TOWN <b>Independence</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Independence San. &amp; Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>316 E. Sea</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>ELIZABETH</b> Last <b>REED</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>16</b> Year <b>1960</b>			
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/1877</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	11. BIRTHPLACE (City and state or country) <b>High Point, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
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13a. FATHER'S NAME <b>John H. Claborn</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Daniel Reed</b>		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Daniel Reed</b> Address <b>109 N. St. Clair Rd. Indep., Mo.</b>			
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Congestive heart failure</b>			<b>2 wks</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		
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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.)			
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20c. TIME OF INJURY <b>3:00 p.m.</b>	Month, Day, Year				
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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
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21. I attended the deceased from **2-1-60** to **2-16-60** and last saw her/him alive on **2-16-60**  
Death occurred at \_\_\_\_\_ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>[Signature]</b> (Degree or title)		22b. ADDRESS <b>Independence</b>		22c. DATE SIGNED <b>2-16-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/19/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Independence, Mo.</b>	
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24. FUNERAL DIRECTOR <b>Geo. Carson &amp; Sons.</b> ADDRESS <b>Indep., Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>2-19-60</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *J. Kenneth Patterson*

Licensed Embalmer No. 4697  
P. O. Address Indy Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.