

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020764
STATE FILE NUMBER

AMENDED

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 197

FILED JUL 11 1961

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jefferson City</u>		Length of stay in 1b <u>24 hrs.</u>	c. CITY OR TOWN <u>Jefferson City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Charles E. Still</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>505 Monroe</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kerma Aurelia Reid</u>			4. DATE OF DEATH Month Day Year <u>July 2, 1961</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/1/1961</u>
9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days <u>24</u> Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Jefferson City, Mo. U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Edgar Leyroy Reid</u>	
13b. MOTHER'S MAIDEN NAME <u>Christine Crues</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Edgar RL Reid</u>		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) <u>Medullary Paralysis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15Min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute circulatory failure</u>			<u>3 hrs</u>
DUE TO (c) <u>Acute Atelectasis</u>			<u>7 hrs</u>
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"/> N- <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m. Month, Day, Year	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 <u>July 1, 1961</u> to <u>July 2, 1961</u> and last saw her/him alive on <u>July 2, 1961</u> Death occurred at <u>11:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>William P. [Signature]</u> (Deputy or title)		22b. ADDRESS <u>500 Lafayette Jefferson City, Missouri</u>	22c. DATE SIGNED <u>7/3/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>7/3/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Longview</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson City Mo.</u>
24. FUNERAL DIRECTOR <u>Dulle Funeral Home J. C. Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6 July 1961</u>	26. REGISTRAR'S SIGNATURE <u>R. P. Harris, Mo. - R. Richter, Reg.</u>

DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ

ITEM NO.

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 James E. Eynard

Licensed Embalmer No. 4978

P. O. Address Jeff. City, 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.