

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

**-61-023860**

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 202

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Adair</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u> Length of stay in 1b <u>2 weeks</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u> c. CITY OR TOWN <u>Winigan</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>Grim-Smith Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>No street address</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ethel</u> Middle <u>Evelyn</u> Last <u>Reed</u>			<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>17</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12/15/1883</u>	<b>9. AGE (last birthday)</b> <u>77</u>	<b>IF UNDER 1 YEAR</b> Months <u>    </u> Days <u>    </u>	<b>IF UNDER 24 HR</b> Hours <u>    </u> Min <u>    </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm home</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Parkersburg, W. Va.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		
<b>13a. FATHER'S NAME</b> <u>Ben Huff</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Artie Brown</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Lloyd Reed</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> Address <u>Carl Reed, Green Castle, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 weeks</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour <u>    </u> a.m. <u>    </u> p.m. Month, Day, Year <u>    </u>	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
<b>21. I attended the deceased from</b> <u>7-11-61</u> <b>to</b> <u>7-17-61</u> <b>and last saw her</b> <u>alive</u> <b>on</b> <u>7-17-61</u> Death occurred at <u>10:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
<b>22a. SIGNATURE</b> (Degree or title) <u>[Signature]</u>			<b>22b. ADDRESS</b> <u>Kirksville, Missouri</u>		<b>22c. DATE SIGNED</b> <u>7-19-61</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>July 19, 1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Price Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) <u>Linn County, Mo.</u> (State)		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Alvan E. Eastman, Green City, Mo.</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>July 24, 1961</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		

J. B. JONES, M.D.

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 Karl R. Kent

Licensed Embalmer No. 4689

P. O. Address Green 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.