

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028116

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 353 Primary Registration District No. 6196 Registrar's No. 11

FILED JUL 25 1961

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sherrilltown</u>	Length of stay in 1b <u>2 yrs</u>	c. CITY OR TOWN <u>Licking Mo</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>3 mi SE of Licking Mo</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Elisha</u> Middle <u>B.</u> Last <u>Reed</u>			4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1961</u>		
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-1896</u>	9. AGE (last birthday) <u>65 +</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Overhead track driver</u>	10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (City and state or country) <u>Shelbyville Ill</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William H Reed</u>	13b. MOTHER'S MAIDEN NAME <u>Eda Florence Carr</u>	14. NAME OF HUSBAND OR WIFE <u>Lela Reed</u>
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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) <u>yes WWI</u>	17. INFORMANT <u>Lela Reed - Licking Mo</u>	Address <u> </u>
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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:		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
IMMEDIATE CAUSE (a) <u>Cardiac + pulmonary arrest</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>pulmonary thrombosis</u>	
DUE TO (c) <u>pulmonary embolus</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary + congestive heart disease</u>		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 Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u>1961</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Licking Mo</u>	COUNTY <u> </u>	STATE <u> </u>
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21. I attended the deceased from <u>1960</u> to <u>61</u> and last saw him alive on <u>July 12, 1961</u> Death occurred at <u>5:57</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>B. J. Myers DO</u> (Degree or title)	22b. ADDRESS <u>Licking Mo</u>	22c. DATE SIGNED <u>7-14-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>7-16-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Licking Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Licking Mo</u>
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24. FUNERAL DIRECTOR <u>Smith-Ferguson</u>	ADDRESS <u>Licking Mo</u>	25. DATE RECD. BY LOCAL REG. <u>July 17, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Edmore E. Hesse</u>
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(Licensed Embalmers Statement on Reverse Side)

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION

AUG 14 1961

AUG 4 1961

JUL 27 1961

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 Robert Ferguson

Licensed Embalmer No. 3945

P. O. Address Licking

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.