

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-031885

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registered on **FILED AUG 17 1962** Primary Registration District No. **4356** Registrar's No. **10**

VS 300
Rev. 4/59

6920
20720
3
4 2
5 2
6
7 1
8 0
9/77X
10
11
1290-2
133-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | | | | | |
|--|------------------------------------|---|---|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY New Madrid | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY New Madrid | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Catron | | | Length of stay in 1b 20 years | | c. CITY OR TOWN Catron | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Shefford Reed | | | First Middle Last | | 4. DATE OF DEATH July 23 1962 | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH About 1884 | 9. AGE (last birthday) 78 | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Tennessee | | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
| 13a. FATHER'S NAME Ben Reed | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | 14. NAME OF HUSBAND OR WIFE | |
| 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. Unknown | | 17. INFORMANT Address Alex Barnes East St. Louis, Ill | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Prostate | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 months |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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 | |
| 19. WAS AUTOPSY PERFORMED? YES <input 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 8-4-59 to 7-23-62 and last saw her/him alive on 7-23-62 Death occurred at 6:00 A. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>James O. Lambert</i> (Degree or title) | | | | 22b. ADDRESS <i>W-0. Lilbourn - Mo</i> | | 22c. DATE SIGNED 7-24-62 | |
| 22a. SIGNATURE | | 23b. DATE July 29, 1962 | | 23c. NAME OF CEMETERY OR CREMATORY Simmons Burial Park | | 23d. LOCATION (City, town, or county) (State) Catron, Mo. | |
| 24. FUNERAL DIRECTOR ADDRESS Ponder Funeral Home Lilbourn, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 7/25/62 | | 26. REGISTRAR'S SIGNATURE <i>D. Scott Justice</i> | |

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 David B. Ponder

Licensed Embalmer No. 5030

P. O. Address Bellevue, 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.