

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-035654

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 2-474 Primary Registration District No. _____ Registrar's No. 335

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 24 1962

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Green Ridge</u>		Length of stay in lb <u>Life</u>	c. CITY OR TOWN <u>Green Ridge</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.F.D. # 1</u>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Nathan</u> Last <u>REED</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1962</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>Sept. 24, 1919</u>	9. AGE (last birthday) <u>42</u>	IF UNDER 1 YEAR Months _____ Days _____
IF UNDER 24 HR Hours _____ Min. _____	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Green Ridge, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U S</u>	
13a. FATHER'S NAME <u>George Reed</u>		13b. MOTHER'S MAIDEN NAME <u>Ester Driskell</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs. Shirley Reed</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. _____	17. INFORMANT Address <u>Mrs. Shirley Reed Green Ridge, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aortic Stenosis; Rheumatic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>
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 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.)			
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 May 10, 1961 to Sept. 12, 1962 and last saw him alive on Sept. 7, 1962
Death occurred at 2:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>T.S. Hogueira, M.D.</u>		22b. ADDRESS <u>1609 S. Limick Sedalia, Mo.</u>		22c. DATE SIGNED <u>9-14-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 15, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>		

24. FUNERAL DIRECTOR ADDRESS <u>Glen E. Heck Funeral Home Green Ridge, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 13, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Francis Shelby per W. Anderson</u>		
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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59
10800
30800
3
4 0
5 1
6
7 0
8 2
9411 X
10
11
1290-0
13 1-0

NOV 8 1962

SEP 27 1962

JAN 8 1963

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 *Glenn E. Heck*

Licensed Embalmer No. 4063

P. O. Address Green Ridge, 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.