

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-046375

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 096 Primary Registration District No. _____ Registrar's No. 68

FILED JAN 2 1963

VS 300
Rev. 4/59

10300
20300

3

4 1

5 2

6

7 1

8 0

9 199.2

10

11

12 90-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Dallas</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dallas</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b <u>21 yrs</u> | c. CITY OR TOWN <u>Buffalo, 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 <u>4 mi So. Buffalo, Mo</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>4 mi S. Buffalo</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Abbie Lula Reed</u> | | 4. DATE OF DEATH Month Day Year <u>12 12 1962</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-17-1876</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | 11. BIRTHPLACE (City and state or country) <u>Farmers Valley, Neb</u> |
| 13a. FATHER'S NAME <u>Joseph Westcott</u> | | 13b. MOTHER'S MAIDEN NAME <u>Julia Stillwell</u> | 14. NAME OF HUSBAND OR WIFE <u>Perry 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. <u>None</u> | 17. INFORMANT Address <u>Mrs Jeanette Ethernan Buffalo, Mo</u> |
| 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>Terminal pneumonia</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2-3 Day</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of tongue - mouth</u> | | | <u>3-4 yrs</u> |
| 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 checked="" 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 checked="" 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>Jan 1958</u> to <u>3 Dec 62</u> and last saw her/him alive on <u>3 Dec 62</u> Death occurred at <u>2:00 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>O. Griffitt M.D.</u> | | 22b. ADDRESS <u>Buffalo Mo</u> | 22c. DATE SIGNED <u>15 Dec 62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-15-1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Farmers Valley</u> | 23d. LOCATION (City, town, or county) (State) <u>Farmers Valley, Neb</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Jones Cantlan Buffalo, Mo</u> | | 25. DATE REGD. BY LOCAL REG. <u>12/27/1962</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

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 Jerry J Cantlon

Licensed Embalmer No. 5153

P. O. Address Buffalo, Me

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.