

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Jackson

Township _____ or Village _____ or City Kansas City (No. 324 St. Wabash)

Registration District No. 389 File No. 20325

Primary Registration District No. 1002 Registered No. 2141

FULL NAME Charles Butler Reynolds Jr.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS		MEDICAL CERTIFICATE OF DEATH
SEX <u>male</u>	COLOR OR RACE <u>white</u>	DATE OF DEATH <u>June 23</u> , 191 <u>2</u> (Month) (Day) (Year)
SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>		I HEREBY CERTIFY, that I attended deceased from <u>June 28</u> , 191 <u>2</u> , to <u>June 23</u> , 191 <u>2</u> , that I last saw him alive on <u>June 23</u> , 191 <u>2</u> , and that death occurred, on the date stated above, at <u>1:30 p.m.</u>
DATE OF BIRTH <u>Nov. 19</u> , 188 <u>8</u> (Month) (Day) (Year)		
AGE <u>23</u> yrs. <u>7</u> mos. <u>4</u> ds.		The CAUSE OF DEATH* was as follows: <u>Acute gastritis</u> <u>1180</u>
OCCUPATION (a) Trade, profession, or particular kind of work <u>Student electrical</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>seven years</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Indo.</u>		(Duration) _____ yrs. _____ mos. <u>2</u> ds.
PARENTS	NAME OF FATHER <u>C. B. Reynolds Sr.</u>	Contributory <u>Broken back, accidental</u> (SECONDARY) <u>about</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>N. Y.</u>	(Duration) _____ yrs. _____ mos. _____ ds.
	MAIDEN NAME OF MOTHER <u>Belle Miller</u>	(Signed) <u>Ernest Baibourg</u> M. D. <u>June 24 1912</u> (Address) <u>611 Sharp</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Indo.</u>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>C. B. Reynolds Sr.</u>		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
(ADDRESS) <u>224 Wabash</u>		Where was disease contracted if not at place of death? _____
Filed <u>JUN 25 1912</u> <u>W. S. Wheeler</u> REGISTRAR		Former or usual residence _____
		PLACE OF BURIAL OR REMOVAL <u>Mt. Washington</u>
		DATE OF BURIAL <u>June 25</u> , 191 <u>2</u>
		UNDERTAKER <u>C. Stine & Son Mfg. Co.</u>
		ADDRESS <u>408 E. 9th</u>

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sar-*

coma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*; *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



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MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Jackson

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Township _____ or Village _____ or City Kansas City (NO. 324 Wabash St. _____ Ward _____)

Registration District No. 399

File No. 20325

Primary Registration District No. 1002

Registered No. 2141

FULL NAME Charles Butler Reynolds Jr.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED OR DIVORCED S.
(Write the word)

DATE OF BIRTH Nov. 19, 1888
(Month) (Day) (Year)

AGE 23 yrs. 7 mos. 4 ds. If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION (a) Trade, profession, or particular kind of work Student, invalid
(b) General nature of industry, business, or establishment in which employed (or employer) 7 yrs.

BIRTHPLACE (City or town, State or foreign country) Mo.

PARENTS NAME OF FATHER L. B. Reynolds Sr. BIRTHPLACE OF FATHER (City or town, State or foreign country) N.Y.
MAIDEN NAME OF MOTHER Miller BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) L. B. Reynolds Sr.
(ADDRESS) 324 Wabash

AUG 7 1918 Filed W. S. Wheeler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 23, 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 28, 1918, to June 23, 1918, that I last saw him alive on _____, 1918, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Acute Gastritis =
Contributory Broken Back - Accidental
(Duration) _____ yrs. _____ mos. 2 ds.

(Signed) Eugene C. Coebaugh M. D.
June 24, 1918 (Address) 611 Sharp.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Mt. Washington DATE OF BURIAL June 25, 1918
UNDERTAKER E. Stone + Son Und. Co. ADDRESS 408 C. 9th St.

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