

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

Do not use this space.

1454

**1. PLACE OF DEATH**

County Jackson  
Township Bar  
City Kansas City (No. 4037 Brooklyn)

Registration District No. 399  
Primary Registration District No. 1002

File No. \_\_\_\_\_  
Registered No. 01  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 4037 Brooklyn St. 15 Ward. \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF John Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 31-1866

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
62 5 3

8. OCCUPATION OF DECEASED Connected with Salvation Army  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lancaster  
(STATE OR COUNTRY) Kentucky

10. NAME OF FATHER Wm. Reid

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Perine

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Perine  
(STATE OR COUNTRY)

14. INFORMANT Mary Huffman  
(Address) 4037 Brooklyn

15. FILED 1/29/29 M. M. Chace  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3 1929

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Myocarditis  
900 9345  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
CONTRIBUTORY (SECONDARY) Coronary Sclerosis  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? yes  
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy  
(Signed) Ken Earls, M. D.  
1/3, 1929 (Address) Kansas

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Moriah DATE OF BURIAL Jan 5 1929

20. UNDERTAKER Cedar Funeral Home ADDRESS K.C. Mo.

N. E.—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.

RECORD

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