

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

Do not use this space.

40839

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kaw Primary Registration District No. 1002 Registered No. _____
 City Kansas City No. 3660 Summit St. 5246 (Ward)

2. FULL NAME

May Reynolds
 (a) Residence. No. 3660 Summit St. 5 Ward. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 27 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 6 23

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

9. BIRTHPLACE (CITY OR TOWN) Maryland
 (STATE OR COUNTRY)

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Robt B Reynolds
 (Address) R. F. D. #4. M. K. C. Mo

15. FILED 120, 1929 M. Grove
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 20 1929

17. I HEREBY CERTIFY, That I attended deceased from 12/13, 1929, to 12/20, 1929 that I last saw him alive on 12/20, 1929, and that death occurred, on the date stated above, at 10:45 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
87.5
97
102 (duration) yrs 1 1/2 mos. ds.
 CONTRIBUTORY (SECONDARY) Hypertension & arteriosclerosis (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 1401 Kansas City Mo.
 (CITY OR PLACE OF BIRTH)

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONDUCTED (PHYSICIAN) Physical signs
 (Signed) J. F. Reinhardt, M. D.
120, 1929 (Address) 821 Maple Blk.

*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 Forest Hill DATE OF BURIAL 12/23 1929

20. UNDERTAKER St. Newcomer's Sons ADDRESS K. C. Mo

WRITE PAINLY, 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.

821 Argyle Bldg
Vic 0800
2:30-5