

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

Do not use this space.

4929

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 399
Primary Registration District No. 1002
No. Kansas City Genl Hosp St. _____ Ward)

File No. _____
Registered No. 579

2. FULL NAME

Charles Reel
(a) Residence. No. 713 Kensington St. 10 Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 27/1859

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, _____ hrs. or _____ min.
<u>70</u>	<u>11</u>	<u>10</u>	<u>10</u>	

8. OCCUPATION OF DECEASED
(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) Cantrell
(STATE OR COUNTRY) Iowa

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Reverend Clerk
(Address) K C Genl Hosp

15. FILED 2/7 1930 M. M. Crowe REGISTRAR
Ass

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-7 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-3 1930 to 2-7 1930 that I last saw him alive on 2-7 1930 and that death occurred, on the date stated above, at 5:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hypostatic Broncho-Pneumonia
with (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Apuoplexy (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED At home
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

19. WHAT TEST CONFIRMED DIAGNOSIS? Aut findings
(Signed) P. E. Williams M. D.

2-7 1930 (Address) Supt K C Genl Hosp

*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 Cantrell, Iowa DATE OF BURIAL 2/8 1930

20. UNDERTAKER Freeman Mortuary ADDRESS 104 W. 4th St.

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.

2
3

