

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

Do not use this space.

13-74
26764
File No. 3369
Registered No.
St. _____ Ward)

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township J. Kan Primary Registration District No. 1002
City J. E. Mo. No. 5916 Harrison

2. FULL NAME

Carl Justin Reynolds
(a) Residence. No. 5916 Harrison St. 8 Ward. _____
(Usual place of abode) (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 <u>m</u>	4. COLOR OR RACE <u>wh.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Oliver Alex Reynolds</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>March 31 1889</u>		
7. AGE YEARS <u>48</u>	MONTHS <u>4</u>	DAYS <u>10</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Contractor</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Painter</u> (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) <u>Stanton</u> (STATE OR COUNTRY) <u>Nebraska</u>		
10. NAME OF FATHER <u>no Record</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>no Record</u>		
12. MAIDEN NAME OF MOTHER <u>no Record</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>no Record</u>		

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-17-1930
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocardial
92A
93C (duration) yrs. mos. ds.
CONTRIBUTORY Chronic Glands cardiac
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) Stanley M. Crowe M. D.
9/17, 1930 (Address) Nepeley Corner

*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.

14. INFORMANT Mrs. Olive H. Reynolds
(Address) 5916 Harrison
15. FILED 9/13 30 M. M. Crowe
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill DATE OF BURIAL 8-13 1930
20. UNDERTAKER Mrs. L. Foster ADDRESS City

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.

