

REC'D MAY 9 1938

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

13520

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township Jackson Primary Registration District No. 1097 Registered No. 1500  
(c) City Jackson City (d) Street No. H Luke Hospital St. 1500  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

(a) Residence, No. 2439 Hill Creek Blvd St. Mo (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 8 - 1870

7. AGE YEARS 67 MONTHS 4 DAYS 27 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookbinder, etc. Physician  
9. Industry or business in which work was done, as saw mill, bank, etc. Merchant  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany13. NAME Don't know14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany15. MAIDEN NAME Don't know16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany17. INFORMANT (ADDRESS) More to the Physician18. BURIAL, CREMATION, OR REMOVAL PLACE Evergreen Mausoleum DATE 4-18-3819. FUNERAL DIRECTOR (ADDRESS) Charles Douglas 8624 Troost20. FILED Apr 7 19 38 M. M. Corone Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 5 193822. I HEREBY CERTIFY, That I attended deceased from Corone to Corone, 19.....

I last saw him..... alive on....., 19..... Death is said

to have occurred on the date stated above, at 6:45 m.

The principal cause of death and related causes of importance were as follows:

Dushterium of the Chest Date of onsetHypertension

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(Licensed Embalmer's Statement on Reverse Side)

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

I 112904

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.

State Board of Health  
1917

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....  
..... L. E. ....  
No.....or by....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

135-20  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township K C Primary Registration District No. 1002 Registered No. 1500  
 (c) City K C (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (c) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Harry J. Reidenhops  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED mar  
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>67</u>	<u>4</u>	<u>27</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
 11. Total time (years) spent in this occupation \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 5, 1938  
 22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
 I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
 The principal cause of death and related causes of importance were as follows:  
 \_\_\_\_\_  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance:  
 \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) C. J. Leitch, M. D.  
 (Address) Prof. Bldg. K. C.

SUPPLEMENTARY

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

FATHER  
 13. NAME \_\_\_\_\_  
 14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

MOTHER  
 15. MAIDEN NAME \_\_\_\_\_  
 16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED Apr 7, 38 Dr. H. Cross  
 Local Registrar.

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

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