

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1121

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Jackson city, mo.
 (c) Name of hospital or institution:
2412 Perry
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution life
 In this community life
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (d) Street No. 2412 Perry
 (e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME DEMPSEY REID 330
 (b) If veteran, name war no
 (c) Social Security No. none

4. Sex Male 5. Color or race negro
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mollie Reid
 6. (c) Age of husband or wife if alive 50 years
 7. Birth date of deceased June 20 1883
 (Month) (Day) (Year)

8. AGE: Years 56 Months 8 Days 16
 If less than one day hr. min.

9. Birthplace Malta Bend Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Janitor

11. Industry or business Fitcherotts Apts

12. Name Albert Reid

13. Birthplace Jenn.
 (City, town, or county) (State or foreign country)

14. Maiden name Belle Johnson

15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mollie Reid

(b) Address 2412 Perry

17. (a) Burial (b) Date thereof 3-26-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln K.C. Mo.

18. (a) Signature of funeral director F. L. ... & ...
 (b) Address 1819 E. 15th St. K.C. Mo.

19. (a) Mar 11, 1940 (b) M. M. Crowe
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 3 - Day 26 - Year 40
 hour 8 A minute EA M.

21. I hereby certify that I attended the deceased from Sept 1937 to 3-26-40, 1940;
 that I last saw alive on 3-26-40, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Death Vegetative Endocarditis Cordis
of Mitral Valve
 Due to Suppurated in Chlorine
Pneumonia Endocarditis Cordis
Mitral Valve
 Other conditions 920
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work? _____ (Specify type of place) _____
 (e) Means of injury _____
 23. Signature Russell ... (M. D. or other) _____
 Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

REV. 5-17-39 I X1931

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Edw. Stevens

Licensed Embalmer No. 2836

P. O. Address 1819 E WTC mo

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.)

If this body is not embalmed, above space should be left blank.