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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

41339  
State File No. 4732  
Registrar's No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County. Jackson  
Kansas City  
(b) City or town  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Mary's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community 40 Yrs.  
years, months or days)

3. (a) PRINT FULL NAME Mrs. Sadie E. Reiff

3. (b) If veteran, No name war. 3. (c) Social Security No

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John Reiff 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased April 13th, 1868  
(Month) (Day) (Year)

8. AGE: Years 72 Months 7 Days 27 If less than one day  
hr. min.

9. Birthplace Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business \_\_\_\_\_

12. Name Jacob S. Hand

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

14. Maiden name Emily Graves

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

16. (a) Informant Rhomanse Sandmeyer  
(b) Address Merriam, Kansas

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/40  
(Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director C.H. Blackman & Son  
(b) Address 2825 Independence Ave.

19. (a) 12-12-40 (Date received local registrar) (b) M. M. Crowe  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 608 India  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10th.  
year 1940 hour 7 minute 05 A.M.

21. I hereby certify that I attended the deceased from 12/7/1940 to 12/10/1940  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Duration 3 days

Due to \_\_\_\_\_

Due to chronic myo carditis

Other conditions 93c  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN  
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 D. H. Russell (M. D. or other)  
Address 3017. 1/2nd ave Date signed 12/14/40

**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 H D Blackman

Licensed Embalmer No. 3639

P. O. Address 2825 Indep. Blvd. NC

**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.**