

LEU MAR 14 1941

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 752

1. PLACE OF DEATH:

(a) County Kansas City - Jackson - Co.
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Kansas City T. B. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23 - da.
(Specify whether
In this community 29
years, months or days)

3. (a) PRINT FULL NAME

Rinehart - Ira Brooks

(b) If veteran, name war None

(c) Social Security No. 705-16-1147

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Mrs. Pauline Rinehart

(c) Age of husband or wife if alive 27 years

7. Birth date of deceased July (Month)

25 (Day) 1911 (Year)

8. AGE: Years 29 Months 6 Days 25

If less than one day
hr. min.

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

10. Usual occupation _____

11. Industry or business Musician

12. Name Ira Brooks Rinehart

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

14. Maiden name Bertha Beng

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

16. (a) Informant Mrs Pauline Rinehart

(b) Address 2826 Prospect

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 1941
(Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director John N. Wagner

(b) Address Kansas City, Missouri

19. (a) 2/21/41 (Date received local registrar) (b) M. M. Croome (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. 2826 Prospect
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20
year 1941 hour 8 minute 16 P. M.

21. I hereby certify that I attended the deceased from Jan. 27, 1941
to Feb. 20, 1941
that I last saw him alive on Feb. 20 at 8:15 P. M.
and that death occurred on the date and hour stated above.

Immediate cause of death For advanced Tuberculosis and Diabetes Mellitus

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

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 Dr. Deane (M. D. or other) _____
Address U.C. To Hospital Date signed _____

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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 *A. R. Haunschild*

Licensed Embalmer No. *4159*

P. O. Address *K. C. Mo.*

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

If this body is not embalmed, fact should be so stated above.

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. 598D
Registrar's No. 752

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Jackson K.C.

(b) City or town K.C.

(c) Name of hospital or institution: R.C. - J.B. Hoop-
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U.S.A.? _____ years.

3. (a) PRINT FULL NAME Ira B. Rinehart

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 29 Months _____ Days _____ If less than one day _____ hr _____ min

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 2/21/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20 - 41
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death For advanced hepatic cirrhosis, medical, pulmonary.

Due to Diabetes Mellitus

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) 13/18

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 [Signature] (M. D. or other) _____
Address K.C. F.B. Hospital Date signed _____

K.C. Mo.

SUPPLEMENTARY

S-5980