

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

Jackson
(a) County
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital of institution **K.C. General Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 days**
(Specify whether years, months or days)
In this community **31 Years**

3. (a) PRINT FULL NAME **ALBERT RINEHOLT**

3. (b) If veteran, name war **No**
3. (c) Social Security No. **496-01-5680**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Mrs. Cora Rineholt** 6. (c) Age of husband or wife if alive **--** years
7. Birth date of deceased **February 25 1865**
(Month) (Day) (Year)

8. AGE: Years **76** Months **10** Days **29** If less than one day hr. min.

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

10. Usual occupation **Hotel Clerk**

11. Industry or business **Lorraine Apartments**

12. Name **Unknown Rinehart**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Mrs. Jarboe**

(b) Address **1014 Broadway**

17. (a) **Cremation** (b) Date thereof **Jan. 26, 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **D. W. Newcomer's Sons**

18. (a) Signature of funeral director **D. W. Newcomer's Sons**

(b) Address **1401 Brush Creek Blvd.**

19. (a) **1-26-42** (b) **M. M. Crow**
(Date received local registrar) (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. **1014 Broadway**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **--**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **24th**
year **1942** hour **2** minute **30** A. M.

21. I hereby certify that I attended the deceased from **1-20-42**, 19, to **1-24-42**, 19;
that I last saw him alive on **1-24-42**, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive heart disease with cardiac decompensation**

Due to **93B**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **See above**

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) (c) Means of injury
23. Signature **Amey R. Thom** (M. D. or other)
Address **Med. Dir. K.C. Gen. Hospital** Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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..... *Amile M. Calhoun*

Licensed Embalmer No..... *3506*

P. O. Address..... *K.C.M.*

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, fact should be so stated above.