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17-39  
X35697

FILED JAN 10 1944  
Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
General Hospital No. 20  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12-16-43-12-18-43  
(Specify whether years, months or days)

In this community Unknown  
(Specify whether years, months or days)

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. 2806 Bell  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 1

3. (a) PRINT FULL NAME HENRY REYNOLDS

3. (b) If veteran, name war NO

3. (c) Social Security No.         

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 18  
year 1943 hour 12:12 minute          A. M.

21. I hereby certify that I attended the deceased from December 16, 1943 to December 18, 1943  
that I last saw him alive on December 18, 1943  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or Race Negro

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

6. (b) Name of husband or wife Melvina Jones (65) 6. (c) Age of husband or wife if alive          years

7. Birth date of deceased Dont Know abt 1873  
(Month) (Day) (Year)

Immediate cause of death Generalized Arteriosclerosis Duration         

8. AGE: Years 70 Months          Days          If less than one day          hr.          min.

Due to Avitaminosis

Due to Dehydration and Cachexia

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

Other conditions (include pregnancy within 3 months of death) 162b

10. Usual occupation Unemployed

Major findings: Of operations         

Of autopsy         

PHYSICIAN           
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business         

12. Name Dont Know

13. Birthplace Dont Know 9  
(City, town, or county) (State or foreign country)

14. Maiden name Dont Know

15. Birthplace Dont Know 9  
(City, town, or county) (State or foreign country)

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?         

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

While at work?          (Specify type of injury) (e) Means of injury         

17. (a) Burial (b) Date thereof Dec. 18-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

23. Signature B. C. Brown (M. D. or other)         

Address Law Dept. 2 600 E 22nd Date signed 12/29/43

18. (a) Signature of funeral director West, J. P. Jones

(b) Address 905 North 4th St.

19. (a) 12-28-43 (b) P. C. Brown  
(Date received local registrar) (Registrar's signature)

**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 *[Handwritten Signature]*  
Licensed Embalmer No. *2710*  
P. O. Address *[Handwritten Address]*

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

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