

FILED JAN 26 1945

State File No. \_\_\_\_\_

120

Registration District No. 149

Primary Registration District No. 1602

Registrar's No. \_\_\_\_\_

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:  
Osteopathic Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 Days  
(Specify whether years, months or days)

In this community 23 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 5447 Highland  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs. Della Reece

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 8th.  
year 1945 hour 8 minute 25 P. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Riley Reece

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased 7 1 1877  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 10  
June 3, 1944 to Jan 8, 1945  
that I last saw her alive on Jan 8, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death bi lateral lobaren pneumonia Duration 9 days

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>6</u>	<u>7</u>	____br. ____min.

Due to Complicated by uremia and nephrosclerosis

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

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

10. Usual occupation At Home

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

Of autopsy \_\_\_\_\_

MOTHER FATHER

12. Name Wesley Hargrave

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

14. Maiden name Martha Hargrave

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Mrs. J. E. Whitesell

(b) Address 5447 Highland

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? \_\_\_\_\_

17. (a) Burial (b) Date thereof 1 10 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Yester Cem. Osceola, Mo.

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address Kansas City, Mo.

19. (a) 1-9-45 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature L. V. Penfield (Date signed 1-9-45)  
Address 6448 Prospect

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

Dr. Penfold  
4748 Prospect

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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 *J. P. Hennick*  
Licensed Embalmer No. 3599  
P. O. Address *H. C. No.*

**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.**