

FILED FEB 6 1945

Registration District No. 149

Primary Registration District No. 1002

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: 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 5 days  
In this community 40 YEARS  
(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. 4311 Independence  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country ---

3. (a) PRINT FULL NAME FRANK Shelby Reynolds

3. (b) If veteran, name war No 3. (c) Social Security No. 466-01-5143

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS. IONE REYNOLDS 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased JUNE - 16 - 1881  
(Month) (Day) (Year)

8. AGE: Years 63 Months 7 Days 1 If less than one day --- hr. --- min.

9. Birthplace SHELBY COUNTY OHIO  
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FIREMAN

11. Industry or business R.C. TERMINAL

MOTHER FATHER { 12. Name JOHN REYNOLDS  
13. Birthplace NEW YORK CITY NEW YORK  
14. Maiden name SARAH E. WOOLLEY  
15. Birthplace SHELBY COUNTY OHIO  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. M. F. COURTNEY  
(b) Address 4311 INDEPENDENCE AVENUE

17. (a) BURIAL (b) Date thereof JAN-19-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director D. A. Newcomer's Son

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 1-18-45 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17  
year 1945 hour 1 minute 55 A. M.

21. I hereby certify that I attended the deceased from Jan. 12, 1945, to Jan. 17, 1945.  
that I last saw him alive on Jan. 17, 1945.  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease  
Duration

Due to.....

Due to.....

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

Major findings: Of operations.....  
Of autopsy None  
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 A. E. Upsher (Specify type of place) (c) Means of injury.....

23. Signature A. E. Upsher (M. D. or other) MD  
Address Med. Dir. Gen'l Hosp. Date signed 1-17-45

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 Emile M. Colburn  
Licensed Embalmer No. 3506  
P. O. Address K.C. Mo

**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.**