

7. S. No. 2
 00M-5-43
 ev. 5-17-39
 I X3667

27323

DEPARTMENT OF COMMERCE .. THE STATE BOARD OF HEALTH OF MISSOURI
 BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED AUG 27 1946

3542

Registration District No. 197

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: 509 Knickerbocker Place
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no.
(Specify whether all her life)
 In this community all her life
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL.")
 (d) Street No. 509 Knickerbocker Place 8
(If rural, give location)
 (e) Citizen of foreign country? no. (Yes or No)
 If yes, name country X

3. (a) PRINT FULL NAME Mrs. Minnie Mae Reynolds, 123
 3. (b) If veteran, name war no.
 3. (c) Social Security No. no.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 15
 year 1946 hour 1:30 minute A. M.

4. Sex female / 5. Color or race white
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Peter Thornton Reynolds
 6. (c) Age of husband or wife if alive dec. years

21. I hereby certify that I attended the deceased from March 11, 1946, to Aug 13, 1946
 that I last saw her alive on Aug 13, 1946
 and that death occurred on the date and hour stated above.

7. Birth date of deceased May 20 1877
(Month) (Day) (Year)

Immediate cause of death Myocardial infarction
 Due to Arteriosclerosis
 Due to 107

8. AGE: Years Months Days If less than one day
69 2 28 5 hr. min.

Other conditions Controlled asthma
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

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

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

10. Usual occupation at home,

11. Industry or business X

12. Name Daniel Jordan 9

13. Birthplace unknown

14. Maiden name Mary Jane Wells (City, town, or county) (State or foreign country)

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

16. (a) Informant L. Logan Smith

(b) Address 509 Knickerbocker Place, K. C., Mo

17. (a) burial (b) Date thereof 8-17-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 8-16-46 (b) Thereldine Holmes
(Date received local registrar) (Registrar's signature)

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?
(Specify type of place)

While at work? _____ (e) Means of injury fall
 23. Signature W. H. ... (M. D. or other)
 Address 1419 Professional Bldg Date signed 8-16-46

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

26163

Poppy Bldg.

Dr. B. Lendis Elliott

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 Robert H Reed
Licensed Embalmer No. 3745
P. O. Address KC. 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.