

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 27 1956

STATE FILE NUMBER **38910**
REGISTRAR'S NO. **3849**

Registration District No. **149** Primary Registration District No. **1002**

Health, Welfare, Public Service
300
1-56
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms written on this form.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY W. Randolph	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN EDWARDSVILLE, Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL Length of stay in lb 16 days		d. STREET ADDRESS 800 S. 94th STREET (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLOYD Middle J. Last REYNOLDS			4. DATE OF DEATH Month 9th Day 1st Year 1956
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-90
9. AGE (In years last birthday) 65 yrs		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY CUSTODIAN	11. BIRTHPLACE (City and state or country) NEWTON, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Cyrus Reynolds	
14. MOTHER'S MAIDEN NAME Mary Ballard		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 6-20-16 to 5-8-19	
16. SOCIAL SECURITY NO. 507.09-47 56		17. INFORMANT Address VA Hospital Records, K.C., Mo.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriolar nephrosclerosis. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) Hypertensive cardiovascular disease.			INTERVAL BETWEEN ONSET AND DEATH Unknown 442X Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART-I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from August 16, 1956 to September 1, 1956 in accordance with the Death occurred at 8:35 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Howard P. Finch M.D. (Degree or title) D		22b. ADDRESS VA Hospital, Kansas City, Mo	22c. DATE SIGNED 9-2-56
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE SEPT. 3 1956	23c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY	23d. LOCATION (City, town, or county) (State) MARYVILLE MISSOURI
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS ADDRESS KANSAS City, Mo	25. DATE RECD. BY LOCAL REG. 9-2-56	26. REGISTRAR'S SIGNATURE Neva Marshall	

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, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Edward M. Ste...*
.....

Licensed Embalmer No. *49*

P. O. Address *K. C. 10*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.