

Health,  
Welfare  
Public  
Service

300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 16 1957

32127

STATE FILE NUMBER 3850

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

4

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Cherokee</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Scammon</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lindeman N.Home</b>			Length of stay in lb <b>6 yrs</b>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>C.</b> Last <b>RENO</b>				4. DATE OF DEATH Month <b>8</b> Day <b>15</b> Year <b>57</b>			
5. SEX <b>Ma</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-11-1877</b>		9. AGE (In years last birthday) <b>80</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Owner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Gen'l Store</b>		11. BIRTHPLACE (City and state or country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Samuel Reno</b>				14. MOTHER'S MAIDEN NAME <b>No Record</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> <b>XX</b>		16. SOCIAL SECURITY NO. <b>512-09-0175</b>		17. INFORMANT <b>Marion A. Reno, 2522 W. 64th St.</b> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Parkinsonism</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>332-X</b>	
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 _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>Aug 1950 to 15 Aug 57</b> and last saw <b>her</b> alive on <b>15 Aug 57</b> . Death occurred at <b>3:45 P.M.</b> on the date stated above, and to the best of my knowledge, from the cause stated.							
22a. SIGNATURE (In ink) <b>J. B. Willoughby M.D.</b>				22b. ADDRESS <b>5905 Main St KC Mo</b>		22c. DATE SIGNED <b>16 Aug 57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>8-16-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Bridget Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Scammon, Kansas</b>	
24. FUNERAL DIRECTOR <b>Magner Funeral Home, KCMo</b>			25. DATE RECD. BY LOCAL REG. <b>8-16-57</b>		26. REGISTRAR'S SIGNATURE <b>Reva Marshall</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
J. B. Willoughby

AE 3-8600  
1:00 P.M.



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 *Alvin R. Haunschild*

Licensed Embalmer No. *41*

P. O. Address *R. E.*

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.