

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006509

FILED VS FEB 23 1960

778

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. L

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>10 Yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Mary's Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3215 Campbell</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROSEZETTA</u> Middle <u>REYNOLDS</u> Last <u>REYNOLDS</u>				4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1/21/1880</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Indiana</u>		11. BIRTHPLACE (City and state or country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>John Huddleston</u>			13b. MOTHER'S MAIDEN NAME <u>Mary ?</u>			14. NAME OF HUSBAND OR WIFE <u>James Z Reynolds</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>CLIFFORD AUSTIN TINA MO.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIAL PNEUMONIA</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>INFLUENZA</u>							<u>14 DAYS</u>
DUE TO (c) <u> </u>							<u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PULMONARY FIBROSIS, SEVERE; PULMONARY INFARCT</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED WHILE AT WORK <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 <u>FEB 1958</u> to <u>FEB 8, 1960</u> and last saw him alive on <u>FEB 8, 1960</u> Death occurred at <u>4:35</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>James W. Fowler, M.D.</u>				22b. ADDRESS <u>1103 GRAND AVE. KANSAS CITY 6, MO.</u>		22c. DATE SIGNED <u>2-9-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-10-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hale Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hale Missouri</u>		
24. FUNERAL DIRECTOR <u>Sheil Funeral Home Kansas City Mo</u>			25. DATE RECD. BY LOCAL REG. <u>2-9-60</u>		26. REGISTRAR'S SIGNATURE <u>Neve Minshall</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

James W. Fowler

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body, whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thomas A. Hill

Licensed Embalmer No. 4954
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.