MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

36797

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 4157
Township Kaw — Primary Registration District No. 1002 — Registered No.
City Kansas City (No. Trinity Lutheran Hospt. St. ..... Ward)

2. FULL NAME Mrs. Flora Reid
(a) Residence. No. 4156 Harrison St., 6 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm. Reid

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 5, 1857

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
70	10	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 54
(c) Name of employer 94

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER A. B. Runkle
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unk.
12. MAIDEN NAME OF MOTHER Martha Murray Nov 2, 1928
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn

14. INFORMANT Wm Reid
(Address) 4156 Harrison

15. FILED 11/7, 1928 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 1 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 24, 1928, to Nov 1, 1928, that I last saw her alive on Nov 1, 1928, and that death occurred, on the date stated above, at 10:42 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary thrombosis
Followed operation for
Ovarian Tumor
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? yes DATE OF Nov 1-28
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Operation
(Signed) H. A. Hickok, M. D
(Address) 1125 Realty Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Forest Hill — DATE OF BURIAL: Nov-3 1928

20. UNDERTAKER: D. W. Newcomer's Sons — ADDRESS: K.C., Mo.

WRITE PLAINLY, WITH UNFADING [illegible] PERMANENT [illegible]
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Acc. 4751.

11:30 - 4

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH. County: Jackson Registration District No.: 399 File No.:
Township: Primary Registration District No.: 1002 Registered No.: 4487
City: K. City (No. , St. Ward)

2. FULL NAME: Mrs Flora Reid

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. . How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	Years	Months	Days	If less than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 11/2, 1928 M. M. Downing Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 1 1928

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h. alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary Thrombosis
Following Operation for
Ovarian tumor
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Non Malignant
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. S. Dieck, M. D.
, 19 (Address) 1625 Oralto.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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N. B. PLAINLY WITH INDELIBLE INK. THE FIGURES ... AGE should be stated EXACTLY. PERSONAL DATA ... of information should be carefully applied ... DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

... ARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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