

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 399

Do not use this space.

33814

1002

1. PLACE OF DEATH

County Jackson

Registration District No. 1002

Township Kaw

Primary Registration District No. Building - 10 + ground

City Kansas City

(No. Building - 10 + ground)

File No. 4266

Registered No. 4266

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Hyde Park Hotel 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 12 - 1879

7. AGE YEARS 50 MONTHS 1 DAYS 2 IF LESS than 1 day, _____ hrs. or _____ min.

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) _____ (c) Name of employer _____

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

10. NAME OF FATHER Charley Valentine Townley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany (STATE OR COUNTRY) Ill.

12. MAIDEN NAME OF MOTHER Mable A. Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) W. Rock Island Ill. (STATE OR COUNTRY)

14. INFORMANT H. N. Reed (Address) Hyde Park Hotel

15. FILED 10/15 1929 M. M. Crowe REGISTRAR asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-14 1929

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 1:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Suicide. Multiple Fractures

169 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Jumped from Balto Blky. H.C. No. (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS histopathological (Signed) Stanley M. Haeff M. D.

10/10, 1929 (Address) Deputy coroner

*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 Osborne Kansas DATE OF BURIAL Oct 16 1929

20. UNDERTAKER Elyar Funeral Home ADDRESS 1809 Linwood

K. B.—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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

