

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

5709
 Do not use this space.

MAR 9 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township 1 Primary Registration District No. 1007 Registered No. 908
 (c) City Kas. City Mo. (d) Street No. 840 N. Chestnut St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs. Rosa Reynolds

(a) Residence, No. 840 north Chestnut St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Albert A Reynolds</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct 12 1878</u>				
7. AGE	YEARS <u>59</u>	MONTHS <u>4</u>	DAYS <u>16</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housekeeper</u>			
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>At Home</u>			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kas. City Kas. Kansas</u>			
	13. NAME <u>William Williams</u>			
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ind.</u>			
	15. MAIDEN NAME <u>Minerva Newkirk</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>			
17. INFORMANT <u>Albert A Reynolds</u> (ADDRESS) <u>840 No Chestnut Kas City Mo</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Maple Hill Cem</u> DATE <u>March 2 1939</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Simmons & Son</u> <u>1404 So 37 th Kas. City Kas.</u>				
20. FILED <u>7 28 39</u> <u>M. M. Brown</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) <u>Feb 18 1939</u>	
22. I HEREBY CERTIFY, That I attended deceased from <u>Dec 31 1937</u> , to <u>Feb 18 1939</u> I last saw her alive on <u>Feb 15 1939</u> . Death is said to have occurred on the date stated above, at m. The principal cause of death and related causes of importance were as follows: <u>Acute Myocarditis</u> Date of onset <u>7/25/39</u> Other contributory causes of importance: <u>Chr. Myocardiot Degeneration</u> <u>Dec 1937</u>	
Name of operation	Date of
What test confirmed diagnosis? <u>Angiogram</u> Was there an autopsy?	
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?	
Where did injury occur?	
(Specify city or town, county, and State)	
Specify whether injury occurred in industry, in home, or in public place.	
Manner of injury	
Nature of injury	
24. Was disease or injury in any way related to occupation of deceased?	
If so, specify	
(Signed) <u>Dee S. Pring</u> M.D. (Address) <u>1107 Bryant Bldg</u>	

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

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

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 this body is not embalmed, above space should be left blank.