

N. 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.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1814

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 days
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME OPHIE REID 36-1
 3. (b) If veteran, No name war _____
 3. (c) Social Security No. 496-01-5187

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Div.

6. (b) Name of husband or wife Claudia Reid 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 29, 1878
(Month) (Day) (Year)

8. AGE: Years 62 Months -- Days 28 If less than one day _____ hr. _____ min.

9. Birthplace Evansville, Ind.
(City, town, or county) (State or foreign country)

10. Usual occupation Cigar Maker

11. Industry or business _____

12. Name Joel D. Reid

13. Birthplace Memphis, Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Allice McConld

15. Birthplace Dayton, O h 10
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature George R. Reid

(b) Address 1704 Jefferson

17. (a) Burial (b) Date thereof Apr. 29, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director J. R. Lewis
 (b) Address City

19. (a) April 29, 1940 (b) M. M. Browe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 1704 Jefferson
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr 11 day 27th
 year 1940 hour 7 minute 15 P. M.

21. I hereby certify that I attended the deceased from 4-25-40, 19____, to 4-27-40, 19____;
 that I last saw h. im alive on 4-27-49, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute coronary occlusion, right, with rupture

Due to _____
 Due to _____

Other conditions See above
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____

28. Signature P. F. DeMorra M.D. (M. D. or other) _____
 Address Supt. K. C. Gen. Hospital, K. C. Mo. Date signed _____

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.....

..... *Myself*, Registered Apprentice No.....
working under my personal supervision.

Signed *Bert Legan*

Licensed Embalmer No. *3979*

P. O. Address *Kansas City, 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 this body is not embalmed, above space should be left blank.