

Registration District No. **15 10399**

Primary Registration District No. **1002**

Registrar's No. **2319**

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: **General Hospital #2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **Unknown** years, months or days

3. (a) PRINT FULL NAME **Josie Reynolds** **543**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Unk.**

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

7. Birth date of deceased **5 4 1861**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	79	0	0	hr. min.

9. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business _____

MOTHER FATHER
12. Name **Unknown**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Record Clerk**

(b) Address **Gen. Hosp. #2**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **6-6-40**
(Month) (Day) (Year)

(c) Place: burial or cremation **Westlawn cemetery K&K**

18. (a) Signature of funeral director **Fynn + Granatnik**

(b) Address **1819 S. 15th**

19. (a) **June 5, 1940** (Date received local registrar) (b) **M. M. Krovine** (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. **2308 Brooklyn Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **4**
year **'40** hour **4** minute **45** P. M.

21. I hereby certify that I attended the deceased from **5-26-'40**, 19____, to **6-4-**, 19____
that I last saw h. e. s. alive on **6-4**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebro-Spinal Meningitis**

Due to **Pneumococcal in origin.**

Due to _____

Other conditions **742**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy **79W**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
361 While at work? _____ (Specify type of place) (e) Means of injury **!**

28. Signature **B. C. [Signature]** (M.D. or other)
Address **Gen. Hosp. #2** Date signed **6-5**

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

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

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..... *Ed. G. Evans*

Licensed Embalmer No. *3826*

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.