. 2
0-39
-39
21492

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

FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31116

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3679

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
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 days (Specify whether
In this community 15 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits write "RURAL")

(d) Street No. 0 Helping Hand Institute
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Frank Newton Reed

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex M.

5. Color or race W.

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife --

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased March (Month) 3rd (Day) 1896 (Year)

8. AGE: Years 44 Months 6 Days 5 If less than one day ..... hr. ..... min.

9. Birthplace Paola? Kansas (City, town, or county) (State or foreign country)

10. Usual occupation Unknown

11. Industry or business Unknown

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Record clerk

(b) Address K.C.General Hospital

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 (Month) 20 (Day) 40 (Year)

(c) Place: burial or cremation Kirksville, Missouri

18. (a) Signature of funeral director Weilert Funeral Home

(b) Address 2332 Monitor Place; K. C. Mo

19. (a) 9-20-40 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 8th year 1940 hour 12 minute 45 A M.

21. I hereby certify that I attended the deceased from Sept. 7th 1940, 19..., to Sept. 8th 1940, 19...; that I last saw him alive on Sept. 8th, 1940, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac decompensation	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 9 d 85	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Drury R. Thorn (M. D. or other)

Address Med.Dir.K.C.Gen.Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Blaine E. Weilent

Licensed Embalmer No. 4075

P. O. Address 2332 Monitor Place

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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