

SEP 7 1943
Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(c) Name of hospital or institution: **St Joseph Hospital**
(d) Length of stay: In hospital or institution **50** years, months or days
In this community **50** years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(d) Street No. **608 Indiana**
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **John Reiff**
(b) If veteran, name war **No**
(c) Social Security No. **192-14-7097**

4. Sex **Male** 5. Color **Wh**
6. (a) Single, widowed, married, divorced **Wid**
6. (b) Name of husband or wife **Mary Reiff**
6. (c) Age of husband or wife if alive **72** years
7. Birth date of deceased **June 25 1871**

8. AGE: Years **72** Months **2** Days **0**
If less than one day **hr. min.**

9. Birthplace **Hagenstown, Maryland**

10. Usual occupation **Home machine shop**

11. Industry or business **N. C. Public Service**

MOTHER FATHER
12. Name **Unknown**
13. Birthplace **Unknown**
14. Maiden name **Mary Horst**
15. Birthplace **Unknown**

16. (a) Informant **Helmer Reiff**

(b) Address **608 Indiana**

17. (a) **Burial** (b) Date thereof **Aug 30 - 1943**

(c) Place: burial or cremation **Memorial Park**

18. (a) Signature of funeral director **W. Blackmer**

(b) Address **City**

19. **Aug 27 - 1943** (b) **J. E. Brown**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **25** year **1943** hour **5** minute **0** P. M.
21. I hereby certify that I attended the deceased from **Aug 24 1943** to **Aug 25 1943**
that I last saw him alive on **Aug 25 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **acute dilatation of heart**
Due to **Intestinal Obstruction**
Due to **172 hr**
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **none**
Of autopsy **none**

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

23. Signature **J. E. Brown**
Address **6520 Ingraham** Date signed **8-26-43**

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

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

*Blackman
bl 4040*

Reiff

05028

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.....*W. H. Blackman*.....

Licensed Embalmer No. *2246*.....

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, fact should be so stated above.