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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30420

State File No.

FILED OCT 29 8 1946

Registration District No.

Primary Registration District No.

1002

Registrar's No.

4108

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City

(c) Name of hospital or institution: 904 East 29th St.

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

(d) Length of stay: In hospital or institution XX

In this community 6 years (Specify whether 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. 904 E. 29th St.

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Mable Marie REIBER

(b) If veteran, name war XX

(c) Social Security No. No

4. Sex Fe 5. Color of race Wh

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

6. (b) Name of husband or wife XX

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

7. Birth date of deceased: April 11, 1904

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>42</u>	<u>5</u>	<u>15</u>	hr. min.

9. Birthplace: Junction City Kansas

(City, town, or county) (State or foreign country)

At Home

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Carl G. Reiber

13. Birthplace Pa.

14. Maiden name Mable McPherson

15. Birthplace Ohio

(City, town, or county) (State or foreign country)

16. (a) Informant Howard Reiber

(b) Address Mason City, Iowa

17. (a) Removal (b) Date thereof 9-28-46

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Junction City, Kansas

18. (a) Signature of funeral director J.W. Wagner

(b) Address Kansas City, Mo.

19. (a) 9-28-46 (b) D. Geraldine Holmes

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26

year 1946 hour 9: minute 55 A. M.

21. I hereby certify that I attended the deceased from March 22nd 1945 to Sept. 26th 1946

that I last saw her alive on Sept 13th 1946

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension & Arteriosclerosis

Duration 28 yr.

Other conditions (Include pregnancy within 5 months of death)

Major findings: 0.30

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? _____

While at work? (Specify type of place) _____

(e) Means of injury _____

23. Signature James J. Smith (M. D. or other) _____

Address 248 Professional Bldg Date signed 9/27/46

K.C. No.

Proof 139
V1-2780

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, fact should be so stated above.