

No. 2
-12-45
-17-39
X47070

FILED OCT 8 1946

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4525 Kensington /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... **20 Yrs** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** - (b) County **Jackson** **48**
(c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL")
(d) Street No. **4525 Kensington** **8**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No) **0**
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **26**
year **1946** hour **2** minute **43 A** M.

21. I hereby certify that I attended the deceased from.....
..... 19....., to..... 19.....;
that I last saw h..... alive on..... 19.....;
and that death occurred on the day and hour stated above.

Immediate cause of death **Deputy Coroner**
Carcinoma of

Due to.....
Bladder

Due to.....
Other conditions..... **52**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy..... **History of Inspection**

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)
..... (Specify nature of injury)
Signature **A.E. Hooper** (M. D. or other)
Address **2800 T. Minn** Date signed **9/27/46**

3. (a) PRINT FULL NAME **Josephine Fell Reichert**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **0**

4. Sex **Femal** / 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Ernest Fred Reichert** 6. (c) Age of husband or wife if alive **52** years

7. Birth date of deceased **Nov 18 1885**
(Month) (Day) (Year)

8. AGE: Years **60** Months **10** Days **8** If less than one day hr. min.

9. Birthplace **New Jersey /**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business.....

12. Name **Colby**

13. Birthplace **No record** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Carrie**

15. Birthplace **No Record** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ernest Fred Reichert**

(b) Address **4525 Kensington**

17. (a) **Burial** (b) Date thereof **Sept 29 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lawn Cem.**

18. (a) Signature of funeral director **Mrs U.L. Orster**

(b) Address **918 Brooklyn**

19. (a) **9-28-46** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

APR 22 1959

APR 22 1959

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 Cortland Munier

Licensed Embalmer No. 3414

P. O. Address 918 Brookside

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.

RC No.