

S. No. 2  
DOM-2-43  
v. 5-17-39  
PI X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30422

State File No.

3809

FILED SEP 16 1946

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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

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:  
2907 LINWOOD BLVD. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community 14 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. 2907 LINWOOD BLVD.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MR. DORA BAIN REIST

3. (b) If veteran, name war No 3. (c) Social Security No. 489-14-0554

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife MRS. MINNIE REIST 6. (c) Age of husband or wife if alive 69 years  
7. Birth date of deceased OCTOBER 29 1876  
(Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days 54 If less than one day hr. min.

9. Birthplace FLORA INDIANA  
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED CASHIER

11. Industry or business ADRAIN MISSOURI

MOTHER FATHER { 12. Name WESLEY REIST  
13. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)  
14. Maiden name BAIN PADEN  
15. Birthplace UNKNOWN  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. MINNIE M. REIST  
(b) Address 2907 LINWOOD BLVD

17. (a) BURIAL (b) Date thereof SEPT. 5 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation MT. MORIAH CEMETERY

18. (a) Signature of funeral director W. H. Newcomer, Inc.  
(b) Address 1401 BRUSH CREEK BLVD

19. (a) 9-5-46 (b) Geraldine Holman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPTEMBER day 3 year 1946 hour 3 minute 45 P. M.  
21. I hereby certify that I attended the deceased from 12 1946 to Sept 3 1946  
that I last saw him emph on Sept 3 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 12 hrs  
Due to Polycythemia Vera 4-5 yrs  
+ arterio-sclerosis

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 836 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 Robert H. Newcomer M.D. or other \_\_\_\_\_  
Address 820 Professional Bldg Date signed 9/4/46

*Organizational Body*

**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 *E. Oscar Wotkey*

Licensed Embalmer No. *1767*

P. O. Address *Kansas City*

**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.**