

FILED FEB 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

643

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>72</u>		PRIMARY REG. DIST. NO. <u>5-289</u>		Registrar's No. <u>6</u>			
1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). STATE <u>Missouri</u> b. COUNTY <u>Clay</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>North Kansas City</u>		c. LENGTH OF STAY (In this place) <u>43 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>North Kansas City</u>		0			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Route # 487 - (Rural)</u>				d. STREET ADDRESS (If rural, give location) <u>Route # 487 -</u>					
3. NAME OF DECEASED (Type or Print) <u>Edith Margaret Rehard</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan - 15 - 1949</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Feb. 12 - 1879</u>			
9. AGE (In years last birthday) <u>69</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Boston Mass - 1</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Gillis</u>		13b. MOTHER'S MAIDEN NAME <u>No Record</u>		14. NAME OF HUSBAND OR WIFE <u>Harry Rehard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>R.A. Rehard</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Branches of pneumonia</u>				2. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart failure</u> DUE TO (c) <u>Senility</u>				1 week	
3. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u>								2 years	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>July</u> , 1947, to <u>Jan 15</u> , 1949, that I last saw the deceased alive on <u>Jan 10</u> , 1949, and that death occurred at <u>7 m.</u> from the causes and on the date stated above.									
23a. SIGNATURE (Type of title) <u>Melvin Lunn Lunn</u>				23b. ADDRESS <u>No. 1000 S. G. St. Mo.</u>		23c. DATE SIGNED <u>1-15-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>Jan. 17 - 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>			
DATE REC'D BY LOCAL REG. <u>Jan 15 - 49</u>		REGISTRAR'S SIGNATURE <u>Beulah Kitchener</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mrs. C. R. Foster - Kansas City Mo.</u>					

(Licensed Embellisher's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

No. 300
10.4824
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0

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

D-2-40

1-25 Pm
2025 District

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed

JOE B. Yoder

Signed.....

Student Embalmer

Licensed Embalmer No.

4173

P. O. Address

K.C. Mo

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.