

FILED APR 25 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12113

1431

BIRTH NO. 23265-55 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY	
c. LENGTH OF STAY (If in place) Life		d. STREET ADDRESS (If rural, give location) 51 3645 MAIN 3510	
d. FULL NAME OF HOSPITAL OR INSTITUTION RESEARCH			
3. NAME OF DECEASED a. (First) DANIEL		b. (Middle) LEE	
c. (Last) REYNOLDS		4. DATE OF DEATH (Month) (Day) (Year) 3-29-55	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER	8. DATE OF BIRTH 3-28-55
9. AGE (in years last birthday) 1		IF UNDER 1 YEAR Months Days 1	
IF UNDER 4 HRS. Hours Min. 1		11. BIRTHPLACE (State or foreign country) MISSOURI	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		12. CITIZEN OF WHAT COUNTRY? U.S.	
10b. KIND OF BUSINESS OR INDUSTRY		13a. FATHER'S NAME ROBERT LECLAIR REYNOLDS	
13b. MOTHER'S MAIDEN NAME DELLA DARLENE ADAMS		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Robert L Reynolds		ADDRESS K.C. Mo.	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature male infant  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause. (a) stating the underlying cause last.  DUE TO (b)  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Only five months and related to the death but not related to the disease or condition causing death. 20 days of age.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19c. 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)		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> 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 March 28, 1955, to March 29, 1955, that I last saw the deceased alive on March 29, 1955, and that death occurred at 1:50 p.m., from the causes and on the date stated above.			
23a. SIGNATURE Harold A. Pallett (Degree or title) c		23b. ADDRESS	
23c. DATE SIGNED 3/29/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-30-55	
24c. NAME OF CEMETERY OR CREMATORY Mt. Washington		24d. LOCATION (City, town, or county) K.C. Mo.	
DATE REC'D BY LOCAL REG. 3.30-55		REGISTRAR'S SIGNATURE neva minshall	
25. FUNERAL DIRECTOR'S SIGNATURE J. P. Sheil		ADDRESS K.C. Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

**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.

Student .....  
Student Embalmer

Signed

*John P. Shul*

Licensed Embalmer No. 3625

P. O. Address W C Md

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.