

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032051
STATE FILE NUMBER
4356

OCT 1 1958 Registration District No. 393 Primary Registration District No. 1002 Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY <i>Clay</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Clay</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>5326 N Cypress</i>		Length of stay in 1b <i>20 gm</i>	d. STREET ADDRESS (If outside, give location) <i>5326 N Cypress</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Michael M. Rinehart</i>			4. DATE OF DEATH Month Day Year <i>Sept 11 1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar 25, 1884</i>
9. AGE (In years Last birthday) <i>74</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales Mgr Real Estate - Self.</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Kansas</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13a. FATHER'S NAME <i>Alexander Rinehart</i>	
13b. MOTHER'S MAIDEN NAME <i>Anna McCallan</i>		14. NAME OF HUSBAND OR WIFE <i>Grace S. Rinehart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>494-40-3261A</i>	
17. INFORMANT Address <i>Mrs Grace Rinehart 5326 N Cypress</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO (b) <i>arterio-sclerosis</i> DUE TO (c) _____ CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Senility, debilitation, prolonged illness</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>14</i> <i>332+</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>Jan 1, 1958</i> , to <i>9-10-58</i> and last saw him alive on <i>9-10-58</i> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Daniel C. Boone MD</i>		22b. ADDRESS <i>2025 SWIFT-NKC, Mo</i>	
22c. DATE SIGNED <i>9-17-58</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	
23b. DATE <i>9-13-58</i>		23c. NAME OF CEMETERY OR CREMATORY <i>D.W. Neuman's Home</i>	
23d. LOCATION (City, town, or county) <i>Kansas City</i>		23e. STATE <i>Mo</i>	
24. FUNERAL DIRECTOR <i>D.W. Neuman's Home N.K.C. Mo</i>		25. DATE RECD. BY LOCAL REG. <i>9-12-58</i>	
26. REGISTRAR'S SIGNATURE <i>Irene Minshall</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Daniel C. Boone

All diseases in Part I must be causally related.

Boyd



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
Signature of Student Embalmer

Signed *Glenn A. Hie*

Licensed Embalmer No. *4586*

P. O. Address *N.C. 16, 1000*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.