

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-029795

STATE FILE NUMBER

AMENDED

Registration District No. 746 Primary Registration District No. 3026 Registrar's No. 450

FILED SEP 13 1961

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN INDEPENDENCE		c. CITY OR TOWN KANSAS CITY	
Length of stay in lb 4 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3713 HARDY FOUR PINES RETIREMENT H		d. STREET ADDRESS (If outside, give location) 5210 BENNINGTON AVE.	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MYRA B REYNOLDS			4. DATE OF DEATH Month Day Year SEPTEMBER 5 1961
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/27/72
9. AGE (last birthday) 89		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (City and state or country) LEXINGTON, KENTUCKY U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME ALGEN S. LEACH		13b. MOTHER'S MAIDEN NAME ANNA LANE	
14. NAME OF HUSBAND OR WIFE JESSE J. REYNOLDS			
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 LEE E. REYNOLDS		Address 5436 PAWNEE LANE SHAWNEE MISSION, KS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO (b) Cerebral hemorrhage DUE TO (c) Senility Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 48 hrs 72 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 a.m. p.m. Month, Day, Year			
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 1950 to 1961 and last saw her live on 9-4-61 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE D. Mcubank M.D. (Degree or title)		22b. ADDRESS 9406 E 63rd St.	
22c. DATE SIGNED 9/6/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE SEPT. 9, '61	23c. NAME OF CEMETERY OR CREMATORIUM BROOKINGS CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. 9-8-61	26. REGISTRAR'S SIGNATURE Alta L. Craig

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

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 Louis Quest

Licensed Embalmer No. 4096

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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