

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-016241

2512

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2512

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 13 1963

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY MIAMI	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY, MISSOURI		c. CITY OR TOWN OSAWATOMIE, KS.	
Length of stay in lb 6 mos.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL, KC, MO.		d. STREET ADDRESS (If outside, give location) 712 Pacific	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last RALPH PETER REYNOLDS			4. DATE OF DEATH Month Day Year APRIL 28, 1963		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/26/98	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (City and state or country) RICHMOND, Ks.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		14. NAME OF HUSBAND OR WIFE Beuna Reynolds			

13a. FATHER'S NAME Carleton Reynolds - D - Ks.	13b. MOTHER'S MAIDEN NAME Belle Porter - D - Ks.	17. INFORMANT VA Hospital Records
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 3/1/17 to 2/6/20		16. SOCIAL SECURITY NO. -
17. INFORMANT ADDRESS Mrs Beuna Reynolds - Osawatomie, Ks.		

18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Ruptured fusiform abdominal aneurysm with massive intra-abdominal hemorrhage		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized atherosclerosis, advanced	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus		PART III. If deceased was female, was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 s.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 **4/28/63 9:00AM** to **4/28/63 3:30 PM** and last saw him alive on **4/28/63**
Death occurred at **3:30 PM 4/28/63** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) STEPHEN PARKS, M.D.	22b. ADDRESS VA Hospital Kansas City, Mo.	22c. DATE SIGNED 4-29-63
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23a. BURIAL, CREMATION, REMOVAL (specify) REMOVAL	23b. DATE APR. 29 1963	23c. NAME OF CEMETERY OR CREMATORY -	23d. LOCATION (City, town, or county) (State) OSAWATOMIE KANSAS
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24. FUNERAL DIRECTOR D.W. Newcomer's Sons, Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 4-29-63	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59

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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)
ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

MAY 20 1963

JUN 11 1963

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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 Dean W Huff

Licensed Embalmer No. 4914

P. O. Address Indy, 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.