

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036399

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5241 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF R. S. Long MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Wyandotte</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>11 Months</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Braton Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>1200 North 18 th St</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mignonette</u> Middle <u>C.</u> Last <u>Reinhardt</u>			4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/19/1871</u>
9. AGE (last birthday) <u>91</u>		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Hillsboro, Ohio</u>
12. CITIZEN OF WHAT COUNTRY <u>United States</u>			
13a. FATHER'S NAME <u>William Schwartz</u>		13b. MOTHER'S MAIDEN NAME <u>Bertha Custer</u>	14. NAME OF HUSBAND OR WIFE <u>George Reinhardt</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>1000</u>	
17. INFIRMITY <u>Mrs. Sinderson</u>		Address <u>Kansas City, Kansas</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>			<u>years</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) <u>Generalized arteriosclerosis with marked senile changes</u>			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 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 <u>9-16-63</u> to <u>9-25-63</u> and last saw her <u>live</u> on <u>9-16-63</u> Death occurred at <u>1:15 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. S. Long M.D.</u> (Degree or title)		22b. ADDRESS <u>Suite 300 Research Medical Office Bldg; 6400 Prospect</u>	22c. DATE SIGNED <u>9-26-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9/27/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LeRoy Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Le Roy, Kansas</u>
24. FUNERAL DIRECTOR <u>R.A. Fulton, Kansas City, Kasas</u>		25. DATE RECD. BY LOCAL REG. <u>9-26-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>

USE BLACK INK OR TYPEWRITER RIBBON

Dr. R. J. Long

EM 3-2822

64 Prospect

Med - Delg -

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 R. A. Fullerton

Licensed Embalmer No. 3035

P. O. Address Kansas City, Kansas

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.