

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040106

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5694 STATE FILE NUMBER

FILED NOV 4 1963

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	P. MC CALLA	SHOULD READ	ITEM NO.
Rev. 4/59									
1									
2 <u>3528</u>									
3									
4 <u>1</u>									
5 <u>2</u>									
6									
7 <u>1</u>									
8 <u>0</u>									
<u>94500</u>									
10									
11									
<u>1277-0</u>									
13									

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>42 YEARS</u>	c. CITY OR TOWN <u>KANSAS CITY</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>JACKSON CO. HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1112 EAST ARMOUR BLVD</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>CATHERINE</u> Last <u>REINHART</u>			4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>18</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>6/9/1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	9. AGE (last birthday) <u>93</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
13a. FATHER'S NAME <u>FRANCIS MARION RIDDELL</u>		13b. MOTHER'S MAIDEN NAME <u>FRANCES COPENHAVER</u>	11. BIRTHPLACE (City and state or country) <u>WINCHESTER, VIRGINIA</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. -----	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
17. INFORMANT <u>6100 TRACY AVE. K.C., MO.</u> <u>MRS. BLAICHE L. MILLER</u>			14. NAME OF HUSBAND OR WIFE <u>DR. E. W. REINHART</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Generalized</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____			
DUE TO (c) _____			
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 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 checked="" 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>10-14-63</u> to <u>10-18-63</u> and last saw her/him alive on <u>10-18-63</u> . Death occurred at <u>1:00</u> <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. P. McCalla M.D.</u>		22b. ADDRESS <u>Jackson Co. Hospital Kansas City Mo</u>	22c. DATE SIGNED <u>10/18/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT. 21 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAN CEMETERY</u>	23d. LOCATION (City, town, or county) <u>KANSAS CITY MISSOURI</u>
24. FUNERAL DIRECTOR <u>1331 BRUSH CREEK BLVD. D.W. NEWCOMERS SONS, K.C., MO.</u>		25. DATE RECD. BY LOCAL REG. <u>10-21-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>

USE BLACK INK OR TYPEWRITER RIBBON

9507 East 63rd Street
Raytown, Mo.
2:00 5:30 P.M.
Mrs. Callie J.E.S. 3600

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 Vern Lawler

Licensed Embalmer No. 4915

P. O. Address K67MO

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.