

NOV 18 1935

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

31902

1. PLACE OF DEATH

County Buchanan,Registration District No. 85
1001

File No. _____

Township _____

Primary Registration District No. _____

Registered No. 1001City St. Joseph,(No. Dr. W. W. Grow's Clinic, 720 Edmond St. Ward)

2. FULL NAME

Hazel Belle Reynolds,(a) Residence, No. 3301 North 11th. St. _____ Ward. _____Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married,

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Ambrose D. Reynolds,

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

April 3, 1893

7. AGE

YEARS

42

MONTHS

6

DAYS

8

IF LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Housekeeping

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

At Home,

10. Date deceased last worked at this occupation (month and year)

October 1935

11. Total time (years) spent in this occupation

22

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Sampson, Missouri,

13. NAME

Frazier Beryl

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Unknown, Unknown,

15. MAIDEN NAME

Unknown,

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Unknown, Unknown,

17. INFORMANT (ADDRESS)

Ambrose D. Reynolds, 3301 North 11th. St.

18. BURIAL, CREMATION, OR REMOVAL

PLACE St. Jo. Mem. Park DATE Oct. 14, 1935

19. UNDERTAKER (ADDRESS)

Heaton-Bigale & Bowman, 319 So. 10th. St. Linn Co. Mo.

20. FILED

OCT 14 1935John R. Bender, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 11th, 193522. I HEREBY CERTIFY, That I attended deceased from Sept 11, 1935, to Oct 11, 1935.I last saw her alive on Oct 11, 1935. Death is said to have occurred on the date stated above, at 9:15 p.m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Cerebral hemorrhage

Other contributory causes of importance:

Ovarian AbscessName of operation Ovaryctomy Date of 10/19/35What test confirmed diagnosis? Chinry Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify: _____

(Signed) Will W. Grow, M. D.(Address) 227 Logan Bldg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON
MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Buchanan Registration District No. 85
 Township St. Joseph Primary Registration District No. 1001
 City St. Joseph (No. Dr. W. Brown Clinic)
 2. FULL NAME Label Belle Reynolds
 (a) Residence, No. 3801 N. 11th St., _____ Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. 1045
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX J 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Oh
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
42 6 8
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____, 19____
 19. UNDERTAKER (ADDRESS) _____
 20. FILED 12-12, 1935 John R. Bender Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 11, 1935
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage Date of onset _____
Other contributory causes of importance:
Quarrian abscess
(Tuberculosis)
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) W. W. Brown, M. D.
 (Address) 122 Logan Bldg

MISSOURI STATE BOARD OF HEALTH
 SUPPLEMENTARY

NOV 30 1968

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