

DEC 9 APR 19 1939

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

10653

Do not use this space.

1. PLACE OF DEATH
(a) County Daniels Registration District No. 248
(b) Township Liberty Primary Registration District No. 41 of 2
(c) City (d) Street No. 5344 Registered No.
(e) Length of residence in city or town where death occurred 21 yrs. mos. ds. (If death occurred in Hospital or Institution, write its name instead of street and number) St. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Luther Reich
(a) Residence, No. Altamont, Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 29 1866

7. AGE YEARS 73 MONTHS 7 DAYS 8 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. M.D. Doctor
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) March 1938 11. Total time (year) spent in this occupation Life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rever, Tennessee

FATHER 13. NAME Josiah Reich
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown North Dakota

MOTHER 15. MAIDEN NAME Louisa Faulk
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown North Dakota

17. INFORMANT (ADDRESS) Mrs J. L. Reich Altamont, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Altamont, Mo. DATE March 9 1939

19. FUNERAL DIRECTOR (ADDRESS) H. F. Powell Kidder, Mo.

20. FILED Mar 12 1939 Mrs J. L. Reich Local Registrar. 225 (Address) Ballatin, Mo.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 7 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 28 1939 to Mar 7 1939

I last saw him alive on Mar 7 1939. Death is said to have occurred on the date stated above, at 5:30 m.

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

Hypostatic Pneumonia ✓

Date of onset

Other contributory causes of importance:

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? No.

If so, specify L. B. Doolin M. D.
(Signed) L. B. Doolin M. D.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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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RECEIVED

District Health Officer No. 11.

District File Number 39-373

Date Filed APR 13 1939

STATEMENT BY LICENSED EMBALMER

I, H. F. Powell, Licensed Embalmer No. 1894

hereby certify that the body recorded on the reverse side of this certificate was embalmed by my self

L. E.

No. _____ or by _____ Registered Apprentice No. _____

working under my personal supervision.

Signed H. F. Powell

Licensed Embalmer No. 1894

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.)

RECEIVED BY CLIX B.H.A. APR 13 1939

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

10653-
Do not use this space.

1. PLACE OF DEATH

(a) County Davess Registration District No. 248
 (b) Township Liberty Primary Registration District No. 5344
 (c) City..... (d) Street No..... St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

John Luther Reich
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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. ormin.
73 7 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19__

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-7, 1947

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:

Hepatic Pneumonia
Bronchial
 Date of onset _____

Other contributory causes of importance:

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) L. P. Doolin, M. D.

(Address) Gallatin

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

1954-55