

JUN 24 1939

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

19972  
Do not use this space.

1. PLACE OF DEATH

(a) County **Stoddard**  
(b) Township **Liberty**  
(c) City

Registration District No. **838**  
Primary Registration District No. **6098P**

Registered No. \_\_\_\_\_

(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 **543 Mary Reynolds**

(a) Residence, No. \_\_\_\_\_ St.  (Usual place of abode, if no street address, write county or city) (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 **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Robt. L. Reynolds**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 6, 1873**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hra. or .....min.  
**65 10 23**

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**  
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) **York, Ill.**

FATHER 13. NAME **Henry G. Hodge**  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

MOTHER 15. MAIDEN NAME **Sarah Park**  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

17. INFORMANT **Robt. L. Reynolds**  
(ADDRESS) **Dudley, Mo.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **York, Ill.** DATE \_\_\_\_\_ 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Blankenship-Strickland**  
**Dexter, Mo.**

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **5/29/39** 19

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 **1:10 am**

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

*Chronic Myocarditis*  
*Bright's disease*  
*(Cardiac decompensation)*

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? *Chloro* 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) *George J. Scharfer*, M. D.

753 (Address) *Dexter, Mo.*

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.

WWW.FAMILYSEARCH.COM

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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 3479

P. O. Address Weymouth, 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 this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

19972  
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1. PLACE OF DEATH  
 (a) County Stoddard Registration District No. 838  
 (b) Township Liberty Primary Registration District No. 6098 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number) \_\_\_\_\_  
 (f) How long in U. S., if of foreign birth? \_\_\_\_\_  
 yrs. mos. ds. yrs. mos. ds.

2. PRINT FULL NAME Mary Reynolds  
 (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 F 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. or \_\_\_\_\_ min.  
65 10 23

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 \_\_\_\_\_

FATHER 14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

MOTHER 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) 5 / 29 / 1939

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:

Chronic myocarditis  
Bright's Disease  
Cardiac Decompensation  
 Other contributory causes of importance:  
Chronic nephritis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? 131 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) George J. Schaefer, M. D.  
 (Address) \_\_\_\_\_

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 MORE

SUPPLEMENTARY

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Stoddard Registration District No. 838  
(b) Township Liberty Primary Registration District No. 6098B Registered No. ....  
(c) City ..... (d) Street No. ....  
(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 Mary Reynolds

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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 Robt L. Reynolds  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-6-1893  
7. AGE YEARS MONTHS DAYS / If LESS than 1 day, ..... hrs. or ..... min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
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) York, Illinois  
13. NAME Henry C. Hodges  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois  
15. MAIDEN NAME Sarah Park  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois  
17. INFORMANT (ADDRESS) Robt G. Reynolds  
Douglas mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE York, Ill DATE 1939  
19. FUNERAL DIRECTOR (ADDRESS) Blankenship - Ste  
Dexter mo  
20. FILED 7/14 19 39 Jennie Burton  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/29 19 39  
22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...  
I last saw him 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:  
Chronic Myocarditis  
Angels Disease  
Stroke Decomposition  
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? .....  
(Signed) Geo J. Schab M. D.  
(Address) Dexter mo

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.