

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18421

Registrar's No. 441

Registration District No. 318

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(c) Name of hospital or institution 908 N. Fremont
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days 2 1/2

8. (a) PRINT FULL NAME John Taylor McReynolds

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Martha McReynolds 6. (c) Age of husband or wife if alive 1 Dec years

7. Birth date of deceased March 28, 1868
(Month) (Day) (Year)

8. AGE: Years 72 Months 1 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace Christian County, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business Own Farm

MOTHER FATHER
12. Name Wesley McReynolds
13. Birthplace Unknown Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Mary Dye
15. Birthplace Unknown Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. P. McReynolds

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 5-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Hills, Mo.

18. (a) Signature of funeral director Alvin G. Schaefer

(b) Address Springfield, Mo.

19. (a) May 16, 1940 (b) M. E. Hurdley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 908 N. Fremont
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
year 1940 hour 19 minute 40 A.M.

21. I hereby certify that I attended the deceased from Jan 2, 1940, to May 15, 1940
that I last saw him alive on May 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Talassa Nerv. Disease
Chronic

Due to _____

Due to _____

Other conditions Agon
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? No (Specify type of place) (e) Means of injury _____

23. Signature Robert J. McNeill (M. D. or other) _____

Address Springfield, Mo. Date signed May 17, 1940

Duration

4 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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.

PLEASE PRINT NAME AND ADDRESS OF EMBALMER ON REVERSE SIDE OF THIS CERTIFICATE

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

Wayne Binkle

Licensed Embalmer No.

3444

P. O. Address

Springfield

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.

J