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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24593

State File No. _____

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 710

1. PLACE OF DEATH:

(a) County BUCHANAN

(b) City or town ST JOSEPH.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2117 FELIX ST. ?
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 2 MONTHS _____
years, months or days _____

8. (a) PRINT FULL NAME ELIZA-REYNOLDS

8. (b) If veteran, name war NO

3. (c) Social Security No. NO.

4. Sex Female 5. Color Wht race Wht

6. (a) Single, widowed, married Single
divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Oct. 3, 1873
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Buchanan Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name James Reynolds

13. Birthplace Buchanan Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Messouri Frouse

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mar Binkley Wright

(b) Address St. Joseph Hospital Bldg 2

17. (a) Burial (b) Date thereof 9-3-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Agency Mo

18. (a) Signature of funeral director Ray Stamer

(b) Address St Joseph Mo

19. (a) July 2, 1940 (b) A J Nestelberg
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County BUCHANAN

(c) City or town ST JOSEPH
(If outside city or town limits, write "RURAL")

(d) Street No. 2117 FELIX ST.
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2
year 1940 hour 6: minute 15 a. M.

21. I hereby certify that I attended the deceased from July 2nd, 1940, to _____, 19____;
that I last saw him viewed on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary Thrombosis

Due to _____

Due to _____

Other conditions none
(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) _____
(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? 85

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Bill Tadlock Coroner (M. D. or other) 5
Address Wing Hall Bldg Date signed 7/2/40

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 John Roy Stanley
Licensed Embalmer No. 2435
P. O. Address St Joseph Ill

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.