

No. 2
-13-40
-17-39
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State File No.

Registrar's No.

Registration District No. 318

Primary Registration District No. 2001

1. PLACE OF DEATH: Green
 (a) County Green
 (b) City or town Springfield, Mo
 (c) Name of hospital or institution Spq Baptist Hospital
 (d) Length of stay: In hospital or institution about 3 das
 In this community years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Green
 (c) City or town Springfield, Mo
 (d) Street No. _____
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Emma Pearl Reno

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex fm 5. Color or race whl 6. (a) Single, widowed, divorced, married

7. Name of husband or wife Chas Reno 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased April 10, 1884
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>1 56</u>	<u>8</u>	<u>27</u>	hr. min.

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

10. Usual occupation Wife

11. Industry or business _____

12. Name Math Smith

13. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Cecil Reno
(b) Address Wheatland Mo

17. (a) burial (b) Date thereof 8/9/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wentons Cem

18. (a) Signature of funeral director J. L. Tucker
(b) Address Wheatland Mo

19. (a) Aug 9, 1940 (b) H. E. Handley MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug day 7 - 1940
 year 11 hour 00 minute 0 M.

21. I hereby certify that I attended the deceased from Aug 4 1940 to Aug 7 1940
that I last saw her alive on Aug 7 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Liver abscess Duration 1 wk

Due to Chronic Cholecystitis ?

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Liver abscess + Cholelithiasis + Cholecystitis
 Of autopsy No

PHYSICIAN Underline the cause to which death should be charged statistically.

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? at home
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Joseph L. Johnston (M. D. or other) _____
Address Springfield, Mo Date signed 8-18-40

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

MOTHER FATHER

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.....

J.P. Lucey

Licensed Embalmer No. *2982*

P. O. Address *Wheatland, Pa.*

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, fact should be so stated above.

X