

No. 2  
4-13-40  
5-17-  
I

FILED MAY 21 1942

Registration District No. \_\_\_\_\_

Primary Registration District No. 6026

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County St. Genevieve  
(b) City or town Rural - Union Township  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
(1. years; months or days)

3. (a) PRINT FULL NAMES

Sarah Ann Reeder

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex FEMALE

5. Color or race White

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

6. (b) Name of husband or wife John Clinton Reeder

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

7. Birth date of deceased June 20 1850  
(Month) (Day) (Year)

8. AGE:

Years 91 Months 10 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace

St. Genevieve Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation

House wife

11. Industry or business

MOTHER FATHER

12. Name William Pinkston

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

14. Maiden name Elizabeth Pinkston

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

16. (a) Informant

MRS. JOHN THURMAN

(b) Address

Desloge, MO

17. (a) Burial

(b) Date thereof 5-10, 1942  
(Month) (Day) (Year)

(c) Place: burial or cremation

Little Vine Cemetery

18. (a) Signature of funeral director

C. B. Boyer

(b) Address

Desloge, MO

19. (a) 5/9/42

(b) Rev. Joseph A. Garner  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Genevieve  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8<sup>th</sup>  
year 1942 hour 3 minute a M.

21. I hereby certify that I attended the deceased from Feb 6  
1940, 19 \_\_\_\_\_, to May 8<sup>th</sup> 1942  
that I last saw her alive on May 7<sup>th</sup> 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death

Hyperstatic Pneumonia

Duration

2 days

Due to

Fracture of left Hip and Cancer of Face.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

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?

While at work

(Specify type of place)

(2) Means of injury \_\_\_\_\_

23. Signature L. M. Hayfield (M. D. or other) MD

Address Jeremiington Mo Date signed 5/8/42

RECEIVED

District Health Officer No. 4

District File Number 14-10-107

Date ~~1/15/1910~~ 1/15/1910

District Health Officer No. 1671

RECEIVED

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

*C. J. Boyer*  
Licensed Embalmer No. 1671

P. O. Address

*Derlague Me*

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.

STANDARD CERTIFICATE OF DEATH

State File No. 13440

Registration District No. 934

Primary Registration District No. 6026

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Genevieve  
 (b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)  
 In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Genevieve  
 (c) City or town Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Ann Peeder

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June - 20 - 18  
(Month) (Day) (Year)

8. AGE: Years 91 Months 10 Days \_\_\_\_\_  
(If less than one day min.)

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8  
 year 1949 hour 3 minute 2 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Hyper-tension

fracture of L. hips and

Due to Cancer of face

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence Dec 3, 1940

(c) Where did injury occur? St. Gen. Co. Mo  
(City or town) (County) (State)

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

While at work? no (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. M. Stanfield (M. D. or other) MD

Address St. Genevieve Mo Date signed \_\_\_\_\_

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

