

FILED FEB 23 1943 4

State File No. _____

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 41

1. PLACE OF DEATH:

(a) County Randolph

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

(c) Name of hospital or institution:
Wabash Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ (Specify whether)
years, months or days

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County St. Louis 17

(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")

(d) Street No. 4015 Pine St
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME William Reynolds

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12th
year 1943 hour 4 minute 35 P.M.

21. I hereby certify that I attended the deceased from February 4, 1943 to February 12, 1943
that I last saw him alive on February 12, 1943
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Maggie Reynolds 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: July 15th 1858
(Month) (Day) (Year)

Immediate cause of death Pneumonia Duration

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>6</u>	<u>27</u>	hr. _____ min. _____

Due to Common Cold

Due to Heart failure

Other conditions old osteomyelitis
(Include pregnancy within 3 months of death)

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

10. Usual occupation Retired Crossing Watchman

11. Industry or business Wabash RR

MOTHER FATHER { 12. Name None

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

14. Maiden name Cynthia Ray

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy _____

16. (a) Informant John Reynolds

(b) Address St. Louis, Mo

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 15th 1943 (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo

18. (a) Signature of funeral director Malsam and Son

(b) Address Moberly, Mo

19. (a) 2-13-43 (Date received local registrar) (b) Irma Haver (Registrar's signature)

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? _____ (Specify type of place) (e) Means of injury _____

23. Signature Erick Heinder (M. D. or other) _____

Address Wabash Hospital, Moberly, Mo Date signed Feb. 12 43

WRITE BLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

36

1036

FEB 26 1943

RECEIVED

District Health Officer No. 10

District File Number 2-43-404

Date Filed FEB 16 1943

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 Frank B. DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly 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, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 7376Registration District No. 294Primary Registration District No. 3056Registrar's No. 41

1. PLACE OF DEATH

- (a) County Randolph
 (b) City or town Mattley
 (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
 In this community _____ years, months or days) (Specify whether

3. (a) PRINT
FULL NAME William Reynolds

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

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

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

7. Birth date of deceased July (Month) (Day) (Year)

8. AGE: Years 84 Months 6 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2
 year 1943 hour _____ minute _____ M.

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

- Immediate cause of death pneumonia bronchial Duration _____

- Due to Common cold

- Due to Heart failure

- Other conditions old osteomyelitis
 (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 _____
 (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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

