

FILED MAR 11 1944

Registration District No. 10

Primary Registration District No. 4162

Registrar's No. 24

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Look Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: at home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community life time years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence  
(c) City or town Look Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. none (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME DAVID PATTERSON REECE

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Floora Grace Reese 6. (c) Age of husband or wife if alive 72 years  
7. Birth date of deceased Jan 30 1864 (Month) (Day) (Year)

8. AGE: Years 80 Months 1 Days 15 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name DAVID PATTERSON REECE

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

14. Maiden name unknown

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

16. (a) Informant Buel R. Reese

(b) Address Chillicothe R. 1

17. (a) Burial (b) Date thereof Feb 18 44 (Month) (Day) (Year)

(c) Place: burial or cremation Look Springs Cem

18. (a) Signature of funeral director H. S. Robinson

(b) Address Jamestown

19. (a) 2-22-1944 (b) L. O. Dickerson (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 15 year 1944 hour 6 minute A M.

21. I hereby certify that I attended the deceased from Feb 16 1944 to Feb 18 1944

that I last saw him alive on Feb 15 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Palsy - Duration \_\_\_\_\_

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

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 \_\_\_\_\_

(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 0

23. Signature G. B. Munnick (M. D. or other)

Address Look Springs Mo Date signed 2-18-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1084

JUL 19 1944

**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 H S R Jackson

Licensed Embalmer No. 3001

P. O. Address Jamestown

**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.**