

FILED MAR 2 1944  
Registration District No. 204

Primary Registration District No. 60 29

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

1. PLACE OF DEATH: *Payzold Reynolds*  
(a) County *Carter*  
(b) City or town *Ruble* *Rural*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: *1 Logan Township*  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community *all life*  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State *mo* (b) County *Reynolds*  
(c) City or town *Ruble* *Rural*  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? *2* years.

3. (a) PRINT FULL NAME *Earline Foster*  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month *Jan* day *24*  
year *1944* hour *6* minute *12* P.M.

4. Sex *Female* 5. Color or race *w*  
6. (a) Single, widowed, married, divorced or *single*  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased *Jan 12 1944*  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *Jan 24*, 19*44*; that I last saw her alive on *Jan 24*, 19*44*; and that death occurred on the date and hour stated above.

8. AGE: Years \_\_\_\_\_ Months *12* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death \_\_\_\_\_  
*Broncho-pneumonia*  
Due to \_\_\_\_\_

9. Birthplace *Ruble* (City, town, or county) *1* (State or foreign country)  
10. Usual occupation \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: *107*  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name *Earl Foster*  
13. Birthplace *Carter Co mo* (City, town, or county) (State or foreign country)  
14. Maiden name *Dorothy Johnson*  
15. Birthplace *Reynolds Co. mo* (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature *Earl Foster*  
(b) Address *Ruble mo*  
17. (a) *Burial* (b) Date thereof *1 25 44*  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation *Edder Cemetery*

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? \_\_\_\_\_

18. (a) Signature of funeral director *Seaton Perwit*  
(b) Address *Van Buren*  
19. (a) *2/16-44* (b) *Essie Evans*  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury *2*  
23. Signature *Frank Pucinski* (D. or other) *D.O*  
Address *Van Buren mo* Date signed *1-25-44*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District No. 112-111

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Date Filed

Serial No. 5,

344197

STATEMENT BY LICENSED EMBALMER

*was not embalmed*

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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**