

S. No. 2
M-2-43
7-5-17-39
P-I X35697

FILED APR 14 1940
Registration District No. **224**

Primary Registration District No. **6225**

Registrar's No. **60**

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

108
0
0

1. PLACE OF DEATH:

(a) County Wagoner

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

(c) Name of hospital or institution: State Hospital # 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 3 yrs + 10 mos years, months or days

3. (a) PRINT FULL NAME Paul Reel

3. (b) If veteran, name war ?

3. (c) Social Security No. ?

4. Sex 35 M 5. Color or race W 6. (a) Single, widowed, married, divorced, married

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

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

8. AGE: Years 35 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Produce work

11. Industry or business _____

MOTHER FATHER

12. Name John S. Reel

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

14. Maiden name Esther Kelley

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

16. (a) Informant Mrs J. D. Reel

(b) Address 119 College St Peoria

17. (a) Burial (b) Date thereof 3-28-40 (Month) (Day) (Year)

(c) Place: burial or cremation Stybam Cemetery

18. (a) Signature of funeral director Frank M. Rogers

(b) Address Peoria Mo

19. (a) 3-29-40 (Date received local registrar) (b) Frank B. Burch (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton

(c) City or town Peoria Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 119 College St
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26 year 1940 hour 2:30 minute _____ P.M.

21. I hereby certify that I attended the deceased from May 24 1940 to March 26 1940 and that I last saw him alive on March 26 1940 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage

Duration _____

Due to _____

Due to _____

Other conditions paralysis (Include pregnancy within 3 months of death) Unknown

Major findings: Of operations no 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) 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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature Frank M. Rogers (M. D. or Other) _____ Address State Hospital # 3 Date signed 3-26-40

RECEIVED

District Health Officer No. 71

District File Number

3-44-518

Date Filed

4-12-44

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

Mariellen J. Frickitt

Licensed Embalmer No.

4566

P. O. Address

Goodman M

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.