DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 8 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15003

Registration District No. 164 | Primary Registration District No. 3032 | Registrar's No. 48

1. PLACE OF DEATH:

(a) County Johnson

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

(c) Name of hospital or institution:
315 E. Gay St. Warrensburg
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No. (Specify whether
In this community 14 Yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED: 51

(a) State Missouri (b) County Johnson 2

(c) City or town Warrensburg, 2
(If outside city or town limits, write "RURAL")

(d) Street No. 315 E. Gay, St.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Anna Reynolds Eckel

3. (b) If veteran, name war No.

3. (c) Social Security No. No.

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

6. (b) Name of husband or wife E. H. Eckel

6. (c) Age of husband or wife if alive Deceased

7. Birth date of deceased Nov. (Month) 1 (Day) 1868 (Year)

8. AGE: Years	Months	Days	If less than one day
75	5	9	hr. min.

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

10. Usual occupation Housekeeper

11. Industry or business Home

FATHER
12. Name William Albert Reynolds
13. Birthplace Cincinnatti (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Anna Todd
15. Birthplace Dovas (City, town, or county) Delaware (State or foreign country)

16. (a) Informant Mrs. Elizabeth Eckel
(b) Address Warrensburg, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-44 (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Hill

18. (a) Signature of funeral director Sweeney Phillips
(b) Address Warrensburg, Missouri

19. (a) April 11 1944 (Date received local registrar) (b) Iola M. Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
year 1944 hour 8 minute 8 A. M.

21. I hereby certify that I attended the deceased from March 2, 19 44 to April 10, 19 44
that I last saw h alive on April 9, 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Tumor of brain	1
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. [illegible] (M. D. or other)
Address Warrensburg, Mo. Date signed 4-11-44

1651

(Licensed Embalmer's Statement on Reverse Side)

MAY 8 1957

MAY 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 Earl Priest

Licensed Embalmer No. 3878

P. O. Address Warrensburg, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 164 Primary Registration District No. 2032 Registrar's No. 48

1. PLACE OF DEATH:
(a) County Johnson
(b) City or town Warrensburg
(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)

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

3. (a) PRINT FULL NAME Anna R. Eckel
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

7. Birth date of deceased Nov. (Month) 1 (Day) 1861 (Year)

8. AGE: Years 75 | Months 5 | Days 27 | If less than one day hrs. min.

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

10. Usual occupation

11. Industry or 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) (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 10
year 1944 hour 6 minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death Tumor of brain	
Due to	
Due to Benign	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 56d
Of autopsy

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature John A Kaw (M. D. or other)
Address Date signed

SUPPLEMENTARY

15003