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FILED SEP 14 1944

State File No. 20
Registrar's No. 20

Registration District No. _____

Primary Registration District No. 5327

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

1. PLACE OF DEATH:

(a) County Crawford Co. Mo.
(b) City or town Rural Cook Station, Mo.
(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 51 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford
(c) City or town Rural
(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 Nevada Reeves

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
6. (b) Name of husband or wife M. R. Nathaniel Reeves
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased 6 (Month) 11 (Day) 1893 (Year)

8. AGE: Years 51 Months 1 Days 21
If less than one day _____ hr. _____ min.

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

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER

12. Name Riley, Sigelt
13. Birthplace Crawford Co. Mo. (City, town, or county) (State or foreign country)

14. Maiden name Natalie Keeler
15. Birthplace N. Y. (City, town, or county) (State or foreign country)

16. (a) Informant Noah Nathaniel Reeves
(b) Address Cook Station, Mo.

17. (a) Burial (b) Date thereof 8-5-44 (Month) (Day) (Year)

(c) Place: burial or cremation Craig Cemetery

18. (a) Signature of funeral director Robert J. Grantham
(b) Address Salem, Mo.

19. (a) 8/10/1944 (Date received local registrar) (b) Will Schuredin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 5 year 1944 hour 9 minute P.M.

21. I hereby certify that I attended the deceased from 7-24-44, 19 to 7-24-44, 19 that I last saw h. alive on 7-24-44, 19 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy
Due to arteriosclerosis or hypertension?

Due to _____

Other conditions (Include pregnancy within 3 months of death) 32

Major findings: Of operations _____
Of autopsy _____

Duration

3 wks

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? _____

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

23. Signature J. D. Schuredin (M. D. or other) D.O.
Address Salem, Mo. Date signed 8-4-44

RECEIVED

District Health Officer No. 5,

District File Number 944481

Date Filed 9-12-44

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.....

me

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Orval E. Lickel*.....

Licensed Embalmer No. 35.....

P. O. Address *S. 7th*.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27587
Registrar's No. 20

Registration District No. _____ Primary Registration District No. 5327

1. PLACE OF DEATH:
(a) County Crawford Co. Mo.
(b) City or town Reform Coal Camp
(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 _____ (Specify whether _____)
years, months or days
3. (a) PRINT FULL NAME Anna N. Reeves
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 _____ years
7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 51 Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) _____ (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 Aug Day 2 Year 1944 hour 9 minute P M.
21. I hereby certify that I attended the deceased from _____ 19____ that I last saw him _____ alive on _____ 19____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

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? _____
While at work? _____ (Specify type of place) _____ (e) Means of injury _____
23. Signature J. H. McLeod (M. D. or other) DO
Address Salem, Mo. Date signed 8/4/44

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

SUPPLEMENTARY

STANDARD CHARTERED BANK

STATEMENT OF ACCOUNTS

PART I - BALANCE SHEET	
ASSETS	LIABILITIES AND CAPITAL
<p>Fixed Assets</p> <p>Investments</p> <p>Loans</p> <p>Other Assets</p>	<p>Capital</p> <p>Reserves</p> <p>Provisions</p> <p>Other Liabilities</p>
Total	Total

STATEMENT OF ACCOUNTS