S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 27 1944

Registration District No. 72

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33747

Primary Registration District No. 1000

Registrar's No. 1054

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: 1824 Clay (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community 80 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 1824 Clay (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Nellie M. Reynolds

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Female

5. Color or race white

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lee

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

7. Birth date of deceased Sept (Month) 15 (Day) 1861 (Year)

8. AGE: Years 83 Months 1 Days 0 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Jerry ?
13. Birthplace ? (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name ?
15. Birthplace ? (City, town, or county) ? (State or foreign country)

16. (a) Informant Miss Susan Reynolds

(b) Address St Joseph, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-44 (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cem

18. (a) Signature of funeral director Fleeman & Son Inc

(b) Address St Joseph, Mo

19. (a) 10-17-44 (Date received local registrar) (b) Helen I. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 15 year 1944 hour 12 minute 40 P.M.

21. I hereby certify that I attended the deceased from 3/28/44, 19..., to 10/14, 1944 that I last saw her alive on 10/14, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Broncho-Pneumonia	2 days
Due to Arteriosclerosis	1 yr
Due to Coronary Disease	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 94a	
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 [signature] (M. D. or other) M.D.

Address 218 N 7th St Joseph Date signed 10/16/44

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(Licensed Embalmer's Statement on Reverse Side)

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 Robert H Apple

Licensed Embalmer No. 3708

P. O. Address St Joseph, Mo.

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.