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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 24 1944

THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

35334

State File No.

Registration District No. 347 Primary Registration District No. 6076 Registrar's No. 2034 39

**1. PLACE OF DEATH:**
(a) County St. Louis County
(b) City or town Jennings Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Elms Convalescent Home (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 (Specify whether
In this community 1 years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Missouri (b) County 96
(c) City or town Jennings (If outside city or town limits, write "RURAL") 0
(d) Street No. 2520 McLaren Ave (If rural, give location) 0
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME James Henry Reeves
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced 2 widower
6. (b) Name of husband or wife Amy Reeves
6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased — (Month) — (Day) 1858 (Year)

8. AGE: Years 86 Months — Days — If less than one day hr. min.

9. Birthplace — (City, town, or county) — (State or foreign country) 9
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace " (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name "
15. Birthplace " (City, town, or county) 9 (State or foreign country)
16. (a) Informant Mrs. Anna Brown
(b) Address 2520 McLaren Av.
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Sept. 28, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crematory
18. (a) Signature of funeral director Chas. A. Bull
(b) Address 4452 Washington Blvd.
19. (a) SEP 28 1944 (Date received local registrar) E. D. McGavran M.D. (Registrar's signature) cms

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept. day 26 year 1944 hour 3 minute 30 P.M.
21. I hereby certify that I attended the deceased from Jan. 5, 1944, to Sept. 26, 1944 that I last saw him alive on Sept. 25, 1944 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Chronic myocarditis | 5yrs? |
| Due to | |
| Due to | |
| Other conditions: Arteriosclerosis (Include pregnancy within 3 months of death) | 5yrs? |

Major findings:
Of operations
Of autopsy 9 yrs

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 0
23. Signature Eugene L. Arnold (M. D. or other) MD
Address 1449 McLaran Date signed

(Licensed Embalmer's Statement on Reverse Side)

P601

OCT 26 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 John Kettler

Licensed Embalmer No. 3880

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, fact should be so stated above.**