No. 2
—5-42
5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 15 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40838

Registration District No. 5-3 Primary Registration District No. 5199 Registrar's No. 102

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Tina Rural (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home 1/2 Mile South of Tina, Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Carroll
(c) City or town Tina Rural (If outside city or town limits, write "RURAL")
(d) Street No. 1/2 Mile South Tina (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Joseph Reber
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Cordelia Reber
6. (c) Age of husband or wife if alive Dead years
7. Birth date of deceased May (Month) 15th (Day) 1859 (Year)
8. AGE: Years 85 Months 6 Days 20 If less than one day hr. min.
9. Birthplace Reading (City, town, or county) Penn (State or foreign country)
10. Usual occupation Farmer
11. Industry or business —
12. Name Elias Reber (FATHER)
13. Birthplace Reading (City, town, or county) Penn (State or foreign country)
14. Maiden name Sarah (MOTHER)
15. Birthplace Don't Know (City, town, or county) — (State or foreign country)
16. (a) Informant Mrs Lou Standley
(b) Address Tina Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/1944 (Month) (Day) (Year)
(c) Place: burial or cremation Vanhorn Acres
18. (a) Signature of funeral director Clifford W Austin
(b) Address Tina Missouri
19. (a) 12-6-1944 (Date received local registrar) (b) Mrs James Rafferty (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 5th year 1944 hour 10 minute 30 A.M.
21. I hereby certify that I attended the deceased from July 10, 1944, to December 5, 1944; that I last saw him alive on Dec. 4, 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac Failure	2 mos.
Due to: Uremic Poison	4 days.
Due to: Senility & Renous Congestion	—
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 Dr. R. W. Matheny (M.D. or other) D.O.
Address Tina, Missouri Date signed 12/5/44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
[illegible] Officer No. 8,
[illegible]
Date Filed 1-10-45

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 Clifford W Fisher

Licensed Embalmer No. 3233

P. O. Address Ina Missouri

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.

S. No. 2B
M—5-43
I 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. Jan

Registration District No. 55 Primary Registration District No. 5199 Registrar's No. 102

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County: Carroll

(b) City or town: Rural - Van Horn Twp

(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 years, months or days)

In this community

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: John J. Reber

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

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: May (Month) W (Day) (Year)

8. AGE: Years 85 Months 6 Days 20 If less than one day min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 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 Feb Day 15 year 1945 hour 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.

Immediate cause of death	Duration
Due to Uremia - due to congestive failure	3 wks.
Due to Heart D.	
Other conditions (Include pregnancy within 3 months of death) Chronic Nephritis	2 yrs.

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: Ch. R. W. Matheny (M.D. or other) MD

Address: Irica Date signed 1-16-45

40838