S. No. 2
M—8-43
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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

Suspension

State File No. 25252

FILED AUG 9 1945

Registration District No. 148 Primary Registration District No. 6175 Registrar's No. 78

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town Milan — Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Liberty
(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 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Sullivan 105
(c) City or town Milan Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Etta Gray Reger
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Fm
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife L. A. Reger
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 11 (Day) 1872 (Year)
8. AGE: Years 73 Months 6 Days 17 If less than one day hr. min.
9. Birthplace Adams Co (City, town, or county) Nebr. (State or foreign country)
10. Usual occupation House Wife
11. Industry or business
MOTHER FATHER
12. Name Jacob Calhoun
13. Birthplace Va (City, town, or county) (State or foreign country)
14. Maiden name Evaline West
15. Birthplace Va (City, town, or county) (State or foreign country)
16. (a) Informant Opal Lee
(b) Address Milan Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 30 45 (Month) (Day) (Year)
(c) Place: burial or cremation Asbury
18. (a) Signature of funeral director Schoenen
(b) Address Milan Mo
19. (a) Aug 2 45 (Date received local registrar) (b) Greta Caldwell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28 year 1945 hour 6 minute P M.
21. I hereby certify that I attended the deceased from Jan 1945 to July 28 1945; that I last saw her alive on July 28 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hemorrhage	5 day
Due to cerebral hem.	2 mo.
Due to nephrosclerosis hypertension	
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
Signature E. K. Simpson (M. D. or other)
Address Milan Date signed 7-29-45

1380 (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 Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Milan, 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.