

FILED SEP 12 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 667

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution three months
(Specify whether
In this community twenty years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 524 Ildereen Drive
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. BETTY LOU REAVES

3. (b) If veteran, name war NONE
3. (c) Social Security No. UNK.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (c) Name of husband or wife Jack Reaves
6. (c) Age of husband or wife if alive UNK. years
7. Birth date of deceased January 31, 1925
(Month) (Day) (Year)

8. AGE: Year 20 Months 6 Days 22
If less than one day hr. _____ min. _____

9. Birthplace Springfield, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name W. A. Morelock
13. Birthplace Springfield, Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Violet Mainbeth
15. Birthplace Lebanon, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Jack Reaves

(b) Address 524 Ildereen Drive, S.F.D., MO

17. (a) Burial (b) Date thereof 8-26-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park cemetery

18. (a) Signature of funeral director Alma [Signature]

(b) Address 534 St. Johns Street

19. (a) 8-28-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23
year 1945 hour 8 minute 50 A.M.

21. I hereby certify that I attended the deceased from 7-4 to 8-23
that I last saw RR alive on 8-23
and that death occurred on the date and hour stated above.

Immediate cause of death Aplastic Anemia Duration 2 Mo
Due to Lymphatic leukemia

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?

23. Signature J.P. [Signature] (M. D. or other) _____
Address Springfield, Mo Date signed 8-25-45

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

29
2
6

31

7

6

0

0

45

25

2 Mo

7

PHYSICIAN

Underline the cause to which death should be charged statistically.

8-25-45

484

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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.....

L. A. Roof
Licensed Embalmer No. 304.....

P. O. Address.....
Springfield, 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.