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

STANDARD CERTIFICATE OF DEATH

State File No. 6715

Registration District No. 278

Primary Registration District No. 305H

Registrar's No.

1. PLACE OF DEATH:

(a) County Pike

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

(c) Name of hospital or institution:
Pike County Hospital
(If not in hospital or institution, write street number or location)

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

In this community _____ years, months or days

3. (a) PRINT FULL NAME Elizabeth Frances 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 wid

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

7. Birth date of deceased Nov 14 1888
(Month) (Day) (Year)

8. AGE: Years 87 Months 2 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER

12. Name Wm Cox

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

14. Maiden name Edna Setters

15. Birthplace Lincoln Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Whitson
(b) Address Leasmo Mo

17. (a) Burial (b) Date thereof 1-18-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Liberty Cemetery

18. (a) Signature of funeral director E. Berry
(b) Address _____

19. (a) Jan 18/46 (b) W. S. Stephens
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike

(c) City or town Leasmo
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 15
year 1946 hour 9 minute 06 P.M.

21. I hereby certify that I attended the deceased from 1-5-46
_____, 19____, to 1-15-46, 19____

that I last saw her alive on 1-15-46, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration _____

Due to Congestive Heart Failure and Pulmonary Infection

Other conditions Asphyxia
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: Of operations _____

Of autopsy 107

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? _____

While at work _____ (Specify type of place)

(a) Signature Charles Jeweller (M. D. or other) _____

(b) Address Louisiana Mo. Date signed 1-16-46

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RECEIVED

District Health Officer No. 10

District File Number 2-46-314

Date Filed FEB 28 1946

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 W. W. Bradley
Licensed Embalmer No. 3966
P. O. Address E. Perry

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.

Registration District No. 278

Primary Registration District No. 3054

1. PLACE OF DEATH:

(a) County Pike
(b) City or town Louisiana
(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 _____)
In this community _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME

Elizabeth F Reynolds

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife (deceased) 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased no. 19 (Month) (Day) (Year)

8. AGE: Years 87 Months 2 Days 14 (if less than one day) _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country) MO

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) Margaret E. Stephens (Registrar's signature)
(Date received local registrar)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____

ADDITIONAL SUPPLEMENTARY INFORMATION

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

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