

S. No. 2
DM-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 24 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40255**
Registrar's No. **1009A**

Registration District No. **128** Primary Registration District No. **2000**

1. PLACE OF DEATH: **GREENE**

(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: **Burge Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **34 days**
(Specify whether in this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Greene** **39**

(c) City or town **Springfield**
(If outside city or town limits, write "RURAL") **6**

(d) Street No. **1470 W. Atlantic**
(If rural, give location) **0**

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Ella Reeves**

3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex **F** **5. Color or race** **W** **6. (a) Single, widowed, married,** **2 divorced Widowed**

6. (b) Name of husband or wife **Wm. W. Reeves (dec.)** **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased **Dec 11 1882**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
64	0	5	_____ hr. _____ min.

9. Birthplace **Stafford Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **Michael Mason**

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

14. Maiden name **Jane Sims**

15. Birthplace **Quincy Ill.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Sam Mason**
(b) Address **1308 E. Locust**

17. (a) Burial (b) Date thereof **12-18-1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Eastlawn**

18. (a) Signature of funeral director **W.L. Dunn**
(b) Address **Springfield, Mo.**

19. (a) 12-18-46 (b) **W. Handy and**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **16th**
year **1946** hour **2** minute **52** A. M.

21. I hereby certify that I attended the deceased from **Nov-10-1946** to **Dec-16-1946**
that I last saw him alive on **12-15-1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of Pancreas**

Due to _____

Due to _____

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

Major findings: **46 G**

Of operations _____

Of autopsy _____

Duration _____

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? _____

While at work? _____ (Specify type of place)

Means of injury _____

23. Signature **Harry P. Knuth** (M. D. or other) _____
Address **450 1/2 E. Connel** Date signed **12/17/46**
Springfield Mo

(Licensed Embalmer's Statement on Reverse Side)

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

39065

111

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 H. J. McCann

Licensed Embalmer No. 2727

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.