

FILED MAR 28 1947

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **110**

5142

1. PLACE OF DEATH:

(a) County Butler
 (b) City or town Neelyville Mo Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Neely Twp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 24 years | (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler **1 1/2**
 (c) City or town Neelyville Mo. Rural **0**
 (If outside city or town limits, write "RURAL")
 (d) Street No. Coiley Grove Settlement **0**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Charlie Mc Reynold

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

4. Sex male | 5. Color or race caud | 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Fannie Mc Reynold | 6. (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased 1 - 6 - 1883
 (Month) (Day) (Year)

8. AGE: Years 64 Months 2 Days 10 If less than one day _____ hr. _____ min.

9. Birthplace Mc. Mining Mo. | (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Esther Mc Reynold

13. Birthplace Mc. Mining Mo. | (City, town, or county) (State or foreign country)

14. Maiden name Martha Walden

15. Birthplace Unknown | (City, town, or county) (State or foreign country)

16. (a) Informant Fannie Mc Reynold wife

(b) Address Neelyville Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 - 18 - 47
 (Month) (Day) (Year)

(c) Place: burial or cremation Neelyville, Mo.

18. (a) Signature of funeral director Fred G. Smith

(b) Address Neelyville Mo.

19. (a) 3/18/47 (Date received local registrar) (b) R. W. Mueller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 18
 year 1947 hour 11:50 minute A M.

21. I hereby certify that I attended the deceased from 12 - 14, 1946 to 3 - 16, 1947
 that I last saw him alive on 12 - 14, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis
 Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 0

23. Signature [Signature] (M. D. or other) _____

Address Cooley Grove Settlement Date signed 3 - 17 - 47

MOTHER FATHER

13B
ADDITIONAL SUPPLEMENTARY INFORMATION
PHYSICIAN

RECEIVED

District Health Office

District File Number 347-

Date Filed 3-25

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 *Fred J. Smith*

Licensed Embalmer No. *4408*

P. O. Address *Sikeston, 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.

2B
45
43880

State File No. April
110
Registrar's No. _____

Registration District No. 43

Primary Registration District No. 5142

1. PLACE OF DEATH:

(a) County Bethel Rural

(b) City or town _____
(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 _____ years, months or days

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 Charlie Mc Reynolds

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race B

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jan 6
(Month) (Day) (Year)

8. AGE: Years 64 Months _____ Day _____ (If less than one day) _____ hr. _____ min.

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1947 hour _____ minute _____ M.

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

Immediate cause of death _____

Duration _____

Tuberculosis, Pulmonary

Due to _____

Due to _____

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? _____

While at work? _____ (Specify type of work)

(c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address Poplar Bluff, Mo Date signed _____

SUPPLEMENTARY

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

S-8105