

S. No. 2
-12-45
5-17-39
I X47070

FILED JUN 14 1947

Registration District No. **42** Primary Registration District No. **1000** Registrar's No. **714**

1. PLACE OF DEATH:

(a) County **Bucklin**

(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **State Hospital # 2**
(If not in hospital or institution, write street number or location)

(d) Length of stay: **1 yr 4 mos 1 day** (Specify whether years, months or days)

In this community **1 year-4mos-1day**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Madaway**

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

(d) Street No. **-----**
(If rural, give location)

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

If yes, name country **No**

3. (a) PRINT FULL NAME: **Amanda M. Reynolds**

3. (b) If veteran, name war **---**

3. (c) Social Security No. **---**

5. Color **Brown**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Albert M. Reynolds deceased** Age of husband or wife if alive **---** years

7. Birth date of deceased **AUGUST 20, 1869**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6** day **15** year **1947** hour **3** minute **15** M.

21. I hereby certify that I attended the deceased from **6-1-47**, 19 **---** to **6-1-47**, 19 **---**

that I last saw him alive on **6-1-47**, 19 **---** and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic pneumonia** Duration **2 days**

Due to **arteriosclerosis**

8. AGE:

Years	Months	Days	If less than one day
86	9	11	hr. min.

9. Birthplace **Not Given Louisville**
(City, town, or county) (State or foreign country)

10. Usual occupation **None Housewife**

Due to **---**

Other conditions **97**
(Include pregnancy within 3 months of death)

MOTHER - FATHER

12. Name **George Reese**

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

14. Maiden name **MARY HUNTER**

15. Birthplace **York Pa**
(City, town, or county) (State or foreign country)

Major findings:
Of operations **---**

Of autopsy **---**

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **E. R. Coakley**

(b) Address **Marionville Mo**

17. (a) Burial, cremation, or removal **burial** (b) Date thereof **6/14/47**
(Month) (Day) (Year)

(c) Place: burial or cremation **M. V. I. M. C. M. E. T. E. R. Y.**

18. (a) Signature of funeral director **Price Funeral Home**

(b) Address **120 E. 1st Marionville, MO**

19. (a) **6-2-47** (b) **K. G. Jenkins**
(Date received local registrar) (Registrar's signature)

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)

(c) Means of injury **---**

23. Signature **E. Coakley** (M. D. or other) **---**

Address **State Hospital # 2** Date signed **6/14/47**

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

St. Joseph, Mo.

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..... *Clem M. Jones*.....
Licensed Embalmer No. *1822*.....
P. O. Address..... *Maryville 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.