

FILED OCT 16 1947

Registration District No. 224

Primary Registration District No. 3072

Registrar's No. 197

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(c) Name of hospital or institution St. Elizabeth's Hospital
(d) Length of stay: In hospital or institution 3 Days
In this community all her life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline
(c) City or town Marshall State
(d) Street No. 316 N Broadway
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME

Lorene Reinhard

(b) If veteran, name war ✓

(c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 20 day Sept
year 1947 hour 9 minute 25 P.M.

21. I hereby certify that I attended the deceased from 1942
to 9-20-1947
that I last saw her alive on 9-20-1947
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Dr. J. G. Reinhard
(c) Age of husband or wife if alive 55 years
7. Birth date of deceased May 14 1892

Immediate cause of death Coronary Artery
Duration 4 yrs

8. AGE: Years 55 Months 5 Days 4 If less than one day 6 hr. min.

9. Birthplace Slater Mo

10. Usual occupation House Wife

11. Industry or business

12. Name G. G. Burns
13. Birthplace Carey Ohio
14. Maiden name Anna Ballard
15. Birthplace Marion Ohio

16. (a) Informant Dr. J. G. Reinhard
(b) Address Slater Mo

17. (a) Funeral (b) Date thereof 9-23-47
(c) Place: burial or cremation Slater City Cemetery

18. (a) Signature of funeral director James J. Sage
(b) Address Slater Mo

19. (a) 9-23-1947 (b) Sidney J. Gray
(Date received local registrar) (Registrar's signature)

Due to
Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(e) Means of injury

23. Signature M. C. Duggins (M. D. or other)
Address Slater Mo Date signed 9/23/47

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 10-9-47

AUG 24 1948

SEP 17 1948

MAY 22 1952

SEP 18 1950

SEP 27 1951

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 James E Jones
Licensed Embalmer No. 3143

P. O. Address Slater

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1100

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. _____

1. PLACE OF DEATH

(a) County Saline
(b) City or town Marshall
(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)

3. (a) PRINT FULL NAME Lorene Lenhard

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 n

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

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

8. AGE: Years 55 Months _____ Days _____ (If less than one day) _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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)

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 locality)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 Year 1947 Hour _____ minute _____ M.

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

Primary site: Left heart

Due to changes to lungs

Due to and heart

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

Major findings: _____ Of operations _____

Of autopsy 50

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) (e) Means of injury _____

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

Address State MO Date signed 10-14-47

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

SUPPLEMENTARY

36742