

No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED DEC 8 1947

Registration District No. 4947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

State File No. 37179

Registrar's No. 1411

1. PLACE OF DEATH:

(a) County: Buchanan
St. Joseph

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

(c) Name of hospital: Missouri Methodist Hospital
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution: 2 days
Lifetime (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Buchanan 11

(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No.: 917 Angelique 7
(If rural, give location)

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

If yes, name country: 0

3. (a) PRINT FULL NAME: KATIE E, REYNOLDS

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: November 30, day 30, year 1947, hour 12, minute :12 A. M.

4. Sex: Female

5. Color or race: White

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

6. (b) Name of husband or wife: Levi

6. (c) Age of husband or wife if alive, dead: dead

7. Birth date of deceased: September 10, 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 28, 1947, to Nov 30, 1947; that I last saw her alive on Nov 29, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage 48 hrs

8. AGE:	Years	Months	Days	If less than one day
1	77	2	20hr.min.

Due to.....

Due to.....

9. Birthplace: Osborne, Missouri 0
(City, town, or county) (State or foreign country)

Other conditions: Generalized Osteo Arthritis
(Include precancer within 3 months of death)

10. Usual occupation: Not employed (pensioner)

Major findings: Inguinal Hernia, Pyelonephritis

Of operations: 837

11. Industry or business: None

Of autopsy: 837

12. Name: Daniel B. Rogers

13. Birthplace: Michigan

14. Maiden name: Emma Wilcox

15. Birthplace: Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant: Inez Leonard

(b) Address: Willow Brook, Missouri

17. (a) Burial, cremation, or removal: Burial (b) Date thereof: 12/1/47
(Month) (Day) (Year)

(c) Place: burial or cremation: Agency, Missouri

18. (a) Signature of funeral director: John C. Rupp

(b) Address: 6054 Pryor Ave., St. Joseph, Mo.

19. (a) 12-3-47 (Date received local registrar)

(b) E. B. Jenkins (Registrar's Signature) 382

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)

23. Signature: Maxwell Day (M. D. or other) 0

Address: 218 N 7th St. Date signed: 12/1/47

St. Joseph, Mo.

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

MOTHER FATHER

many years

PHYSICIAN'S

Underline the cause of which death should be charged statistically.

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.....

Licensed Embalmer No. *3,986*

P. O. Address *St. Joseph, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in this 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.