

FILED DEC 8 1947

Registration District No. **10**

Primary Registration District No. **5696**

Registrar's No. **152**

1. PLACE OF DEATH:

(a) County Livingston  
(b) City or town Rural - Jackson Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: — (Specify whether  
In this community Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston  
(c) City or town Rural (If outside city or town limits, write "RURAL") 59  
(d) Street No. Jackson Twp (If rural, give location) 0  
(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country: —

3. (a) PRINT FULL NAME James P. Reeter

3. (b) If veteran, name war: — 3. (c) Social Security No. —

4. Sex Male 5. Color or race White 6. (a) Single, widowed, divorced, Widowed  
6. (b) Name of husband or wife Maudie Reeter 6. (c) Age of husband or wife if alive — years  
7. Birth date of deceased April 6, 1880  
(Month) (Day) (Year)

8. AGE: Years 67 Months 7 Days 11 If less than one day — hr. — min.

9. Birthplace Livingston Co., Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business —

MOTHER FATHER { 12. Name Phillip Reeter 4  
13. Birthplace Germany (State or foreign country) 4  
14. Maiden name Rachael Smith  
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Mr. Will Reeter  
(b) Address Chillicothe, Mo

17. (a) Burial (b) Date thereof 11/19/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield Cem

18. (a) Signature of funeral director W. J. Landon

(b) Address Chillicothe, Mo

19. (a) Nov-18-47 (b) Francis B. Neill  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17  
year 1947 hour 2 minute 30 P.M.

21. I hereby certify that I attended the deceased from 19 to 19  
that I last saw Substituted  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage  
Due to Death instantaneous

Due to Death instantaneous

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 3 A  
Of autopsy —

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? —

(Specify type of place) —  
What was the cause of injury? — (e) Means of injury —

23. Signature W. J. Landon (Dr. D. of other) 3  
Address Chillicothe, Mo Date signed 11/19/47

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

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

NOV 9 1948

---

---

**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 *Ronald F. Gardner*  
Licensed Embalmer No. *4191*  
P. O. Address *Chillicothe, 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.