FILED AUG 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29042 State File No. 40

BIRTH NO. 46964-49 REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 4515 Registrar's No.

1. PLACE OF DEATH
a. COUNTY: Sullivan
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Milan
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Simpson's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Sull.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Milan
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): Margaret
b. (Middle): Marie
c. (Last): Reger

4. DATE OF DEATH (Month): 8 (Day): 1 (Year): 49

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 8-1-49
9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.: 5

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Milan Mo
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Ross Reger
13b. MOTHER'S MAIDEN NAME: Helen Haiden
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Ross Reger
ADDRESS: Milan Mo

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature birth — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

776 X

19a. DATE OF OPERATION: Aug 18 1949
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-1, 1949, *to* 8-1, 1949, *that I last saw the deceased alive on* 8-1, 1949, *and that death occurred at* 1:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E W Simpson MD
23b. ADDRESS: Milan
23c. DATE SIGNED: 8-3-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-2-49
24c. NAME OF CEMETERY OR CREMATORY: Bairdstown
24d. LOCATION (City, town, or county) (State): Milan Mo

DATE REC'D BY LOCAL REG.: Aug. 18-1949
REGISTRAR'S SIGNATURE: Mrs. H. B. Harris 32C
25. FUNERAL DIRECTOR'S SIGNATURE: Schoene & Dwight Schoene
ADDRESS: Milan Mo

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED AUG 22 1949
District Health Officer No. 1
District File Number 8-49-144
Date Filed AUG 22 1949

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
Not Embalmed, Student Embalmer No.
working under my personal supervision.

Signed Dwight Simone

Signed
Student Embalmer

Licensed Embalmer No. 2647

P. O. Address Milan - Ills

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi
the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.