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FILED NOV 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34521**
Registrar's No. **20**

| | | | | | | | |
|--|----------------------------------|--|---|--|--|---|--|
| BIRTH NO. _____ | | REG. DIST. NO. 242 | | PRIMARY REG. DIST. NO. 5830 | | Registrar's No. 20 | |
| 1. PLACE OF DEATH a. COUNTY New Madrid | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY New Madrid | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) Rural | | c. LENGTH OF STAY (In this place) 10yrs | | c. CITY (If outside corporate limits, write RURAL and give township) Rural | | | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION | | | | d. STREET ADDRESS (If rural, give location) | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Orba | | | b. (Middle) | | c. (Last) Reynolds | | 4. DATE OF DEATH (Month) (Day) (Year) 10 6 1949 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) never married | | 8. DATE OF BIRTH 12/10/1919 | 9. AGE (In years last birthday) 29 | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Jasper Ark. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13a. FATHER'S NAME Geo. Reynolds | | | 13b. MOTHER'S MAIDEN NAME Minnie Strode | | 14. NAME OF HUSBAND OR WIFE none | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Horace Wise Morehouse 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, asthma, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) John Pneumonia | | | INTERVAL BETWEEN ONSET AND DEATH 5 day |
| | | | | ANTECEDENT CAUSES Morbidity 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. | | | 490X |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 10-1-1949 to 10-6-1949 , that I last saw the deceased alive on 10-6-1949 , and that death occurred at 10:00A.M. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) L. M. Davis, M.D. | | | | 23b. ADDRESS Morehouse, Mo. | | 23c. DATE SIGNED 10-14-49 | |
| 24a. BURIAL, CREMATION REMOVAL (Specify) Burial | | 24b. DATE 10/11/49 | | 24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 24d. LOCATION (City, town, or county) (State) Sikeston Mo. | |
| DATE REC'D BY LOCAL REG. 10/27-49 | | REGISTRAR'S SIGNATURE Thomas M. Sheeter | | 25. FUNERAL DIRECTOR'S SIGNATURE Welsh Funeral Home | | ADDRESS Sikeston Mo. | |

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

RECEIVED OCT 29 1949
District Health Office No. 2
District File Number 1044-110
Date Filed _____

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 _____

Student Embalmer No. _____

_____ing under my personal supervision.

dent
Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Stenton Mo

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

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