

FILED JUL 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20812

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 383 PRIMARY REG. DIST. NO. 3037 Registrar's No. 251

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Mt Vernon</u>		c. LENGTH OF STAY (in this place) <u>3 yrs</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mrs A L Mosby Res</u>		d. STREET ADDRESS (If rural, give location) <u>Y</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u> b. (Middle) <u>Hopper</u> c. (Last) <u>Reaver</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 6 - 1950</u> <u>July 17 1868</u>
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5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 17 - 1868</u>	9. AGE (in years last birthday) <u>81</u>	10. UNDER 1 YEAR Months <u>10</u> Days <u>19</u>	11. UNDER 1 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Household duties</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Inde Co - Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John W Reaver</u>	13b. MOTHER'S MAIDEN NAME <u>Abijah Brite</u>	14. NAME OF HUSBAND OR WIFE <u>Thaddeus</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>no</u>	17. INFORMANT'S SIGNATURE OR NAME <u>R.E. McCause</u>	18. ADDRESS <u>Mt Vernon Mo</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>General debility from confinement</u>		<u>18 mo</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fractured R. hip.</u>		<u>1 year 11 mo</u>
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>E 90°</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. (AUTOPSY?) YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>fractured hip home</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Lawrence Mo</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Just fell off of step.</u>
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22. I hereby certify that I attended the deceased from July 31, 1948 to July 16, 1950, that I last saw the deceased alive on July 6, 1950, and that death occurred at 7 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>R. W. Johnson M.D.</u>	23b. ADDRESS <u>Mt Vernon Mo</u>	23c. DATE SIGNED <u>7-7-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	24b. DATE <u>July 9 - 50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>S.O.C.F.</u>	24d. LOCATION (City, town, or county) (State) <u>Near Mt Vernon Mo</u>
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DATE REC'D BY LOCAL REG. <u>7-7-50</u>	REGISTRAR'S SIGNATURE <u>W Cecil Hendricks</u>	25. GENERAL DIRECTOR'S SIGNATURE <u>Geo. B. Cline</u>	ADDRESS <u>Mt Vernon Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 7-8-50

District Health Officer No. 5,

District File Number 750-780

Date Filed 7-8-50

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. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

George B. Orr

Licensed Embalmer No. 946

P. O. Address McTearon

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

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