

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36260

FILED OCT 27 1953

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2001 Registrar's No. 4757

|   |  |   |  |                                  |  |
|---|--|---|--|----------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>JASPER</b>   |  | 2. USUAL RESIDENCE: (Where deceased lived, or if institution, residence before admission).<br>a. STATE<br><b>MISSOURI</b> |  | b. COUNTY<br><b>JASPER</b>       |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN<br><b>JOPLIN</b> |  | c. LENGTH OF STAY (In this place)<br><b>8 DAYS</b>  |  | c. CITY OR TOWN<br><b>JOPLIN</b> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST. JOHN'S HOSPITAL</b>                               |  |   |  |                                  |  |
| e. STREET ADDRESS (If rural, give location)<br><b>308 CONNOR</b>                                    |  |   |  |                                  |  |

|  |                          |                              |                       |                    |                       |
|--|--------------------------|------------------------------|-----------------------|--------------------|-----------------------|
| 3. NAME OF DECEASED<br>(Type or Print) |                          |                              | 4. DATE OF DEATH      |                    |                       |
| a. (First)<br><b>JOHN</b>              | b. (Middle)<br><b>B.</b> | c. (Last)<br><b>REYNOLDS</b> | (Month)<br><b>Oct</b> | (Day)<br><b>20</b> | (Year)<br><b>1953</b> |

|                       |                                  |  |  |  |                                   |                                  |
|-----------------------|----------------------------------|--|--|--|-----------------------------------|----------------------------------|
| 5. SEX<br><b>MALE</b> | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b> | 8. DATE OF BIRTH<br><b>JULY 22, 1879</b> | 9. AGE (In years last birthday)<br><b>74</b> | IF UNDER 1 YEAR<br>Months<br>Days | IF UNDER 2 HRS.<br>Hours<br>Min. |
|-----------------------|----------------------------------|--|--|--|-----------------------------------|----------------------------------|

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED BUSINESS MANAGER: STEAM FITTERS UNION</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>STEAM FITTERS UNION</b> |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>JOPLIN, MISSOURI</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |
|---|--|---|--|---|--|--|--|

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 13a. FATHER'S NAME<br><b>JOHN B. REYNOLDS</b> |  | 13b. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b> |  | 14. NAME OF HUSBAND OR WIFE<br><b>EDNA MAY REYNOLDS</b> |  |
|---|--|---|--|---|--|

|   |  |                                       |  |   |  |                              |  |
|---|--|---------------------------------------|--|---|--|------------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> |  | 16. SOCIAL SECURITY NO.<br><b>NO.</b> |  | 17. INFORMANT'S SIGNATURE OR NAME<br><b>EDNA MAY REYNOLDS, 308 CONNOR</b> |  | ADDRESS<br><b>308 CONNOR</b> |  |
|---|--|---------------------------------------|--|---|--|------------------------------|--|

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> |  | MEDICAL CERTIFICATION   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |  |
|  |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hemorrhage</b>  |  |  |  |   |  |
|  |  | ANTECEDENT CAUSES<br><br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Duodenal ulcer</b> |  |  |  | Unknown   |  |
|  |  | DUE TO (c) <b>Acute Non-functioning gall bladder one y</b>  |  |  |  | week  |  |
|  |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                           |  |  |  |   |  |

|                        |  |                                  |  |  |  |   |  |
|------------------------|--|----------------------------------|--|--|--|---|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input 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)<br><b>586X</b> |  |
|--|--|--|--|--|--|

|   |  |  |  |                            |  |
|---|--|--|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) |  | 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 Oct. 13 1953, to Oct. 20, 1953, that I last saw the deceased alive on Oct. 20 1953, and that death occurred at 7 P.m., from the causes and on the date stated above.

|   |  |  |  |                                     |  |
|---|--|--|--|-------------------------------------|--|
| 23a. SIGNATURE (Degree or title)<br><b>Raymond D. Durb...</b> |  | 23b. ADDRESS<br><b>607 Frisco Bldg., Joplin,</b> |  | 23c. DATE SIGNED<br><b>10-22-53</b> |  |
|---|--|--|--|-------------------------------------|--|

|  |  |                              |  |  |  |   |  |
|--|--|------------------------------|--|--|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> |  | 24b. DATE<br><b>10-23-53</b> |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>MT. HOPE CEMETERY</b> |  | 24d. LOCATION (City, town, or county) (State)<br><b>WEBB CITY, MISSOURI</b> |  |
|--|--|------------------------------|--|--|--|---|--|

|   |  |   |  |   |  |                       |  |
|---|--|---|--|---|--|-----------------------|--|
| DATE REC'D BY LOCAL REG.<br><b>10-24-53</b> |  | REGISTRAR'S SIGNATURE<br><b>Edna May Reynolds</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>STEVE PARKER MORTUARY, JOPLIN, MO.</b> |  | ADDRESS<br><b>138</b> |  |
|---|--|---|--|---|--|-----------------------|--|

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

RECEIVED OCT 26 1953

Jasper County Health Office

County File Number 53-10-853

Date Filed OCT 26 1953

NOV 2 1953

MAY 13 1954

JAN 15 1962

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.....  
Signature of Student Embalmer

Signed F. M. Jones.....

Licensed Embalmer No. 2319.....

P. O. Address Joplin, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.