

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5380

State File No.

FILED FEB 23 1954

BIRTH NO. _____ REG. DIST. NO. 183 PRIMARY REG. DIST. NO. 4296 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Lin Co. Mo.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Lin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Browning Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Browning Mo.</u>	
c. LENGTH OF STAY (in this place) <u>1 hr</u>		d. STREET ADDRESS (If rural, give location) <u>550</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>D. T. B. Mc. Artor office</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Rosa</u> b. (Middle) <u>Marie</u> c. (Last) <u>Reynolds Mc Kay</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>2-13-54</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 8th 1889</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>5</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Station agent</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Wagon, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Hugh Reynolds</u>	13b. MOTHER'S MAIDEN NAME <u>May Francis Garahl</u>	14. NAME OF HUSBAND OR WIFE <u>Joseph Mc Kay</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If Yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>707-09-7432</u>	17. INFORMANT'S SIGNATURE OR NAME <u>C.H. Reynolds</u> ADDRESS <u>20239 Indiana St Okla City</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 <u>indefinite</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive vascular disease</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death. <u>Retired detachment, repaired</u>		<u>6 months</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>443X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 1952 to Feb 1954, that I last saw the deceased alive on Feb 13, 1954 and that death occurred at 10:30 am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Howard Carter M.D.</u>	23b. ADDRESS <u>Browning, Mo.</u>	23c. DATE SIGNED <u>Feb 14, 1954</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Feb 16 - 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Country</u>	24d. LOCATION (City, town, or county) (State) <u>Browning, Okla.</u>
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DATE REC'D BY LOCAL REG. <u>Feb. 18 '54</u>	REGISTRAR'S SIGNATURE <u>Elva Crookshanks</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Brothers</u> ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 12 1954

APR 5 1954

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 *W. R. Wright*

Licensed Embalmer No. *4655*

P. O. Address *Federal, 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.