

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34346

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

FILED NOV 9 - 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 157 PRIMARY REG. DIST. NO. 2028 Registrar's No. 2-20

1. PLACE OF DEATH  
a. COUNTY Jasper

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Missouri b. COUNTY Jasper

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Carthage c. LENGTH OF STAY (in this place) 73 yrs. c. CITY OR TOWN Carthage d. Is residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION 631 So. McGregor STREET ADDRESS (If rural, give location) 631 So. McGregor 0493

3. NAME OF DECEASED a. (First) Armilda b. (Middle) Halliburton c. (Last) McReynolds 4. DATE OF DEATH (Month) (Day) (Year) 10 27 1954

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single 8. DATE OF BIRTH 2-4-1881 9. AGE (In years last birthday) 73 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) at home 10b. KIND OF BUSINESS OR INDUSTRY at home 11. BIRTHPLACE (City and State or Foreign Country) Carthage, Mo. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Samuel McReynolds 13b. MOTHER'S MAIDEN NAME Helen Marr Halliburton 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) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Allen McReynolds ADDRESS 911 So. Garrison

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, ashenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Bronchial Asthma 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 Myocardial Weakness INTERVAL BETWEEN ONSET AND DEATH 3 yrs  
2-3 yrs

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION 241X 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) (Minute) \_\_\_\_\_ 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 Dec 1949, to 10-27, 1954, that I last saw the deceased alive on 10-27, 1954, and that death occurred at 11:20 m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) \_\_\_\_\_ 23b. ADDRESS Carthage, Mo 23c. DATE SIGNED 10-28-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 10-30-54 24c. NAME OF CEMETERY OR CREMATORY Park Cemetery 24d. LOCATION (City, town, or county) (State) Carthage, Mo.

DATE REC'D BY LOCAL REG. 10-29-54 REGISTRAR'S SIGNATURE [Signature] 139 25. FUNERAL DIRECTOR'S SIGNATURE Knell Mortuary ADDRESS Carthage, Mo.

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

Date Filed  
NOV 8 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.....  
Signature of Student Embalmer

Signed..... Robert H. Knell

Licensed Embalmer No. 445

P. O. Address Carthage

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.