

FILED JAN 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3731

BIRTH NO.		REG. DIST. NO. 374		PRIMARY REG. DIST. NO. 4647		Registrar's No. 7	
1. PLACE OF DEATH a. COUNTY Worth				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Worth			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Grant City,		c. LENGTH OF STAY (In this place) 2 1/2 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Grant City		1130	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) 0			
3. NAME OF DECEASED (Type or Print)		a. (First) Dorus		b. (Middle) D.		c. (Last) Reeves	
4. DATE OF DEATH		5. SEX Male 0		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Feb. 7, 1868		9. AGE (In years last birthday) 86		10. MONTHS 86		11. IF UNDER 1 YEAR Days	
12. IF UNDER 12 Hrs. Hours		13. IF UNDER 1 MIN. Mins.		14. BIRTHPLACE (City and State or Foreign Country) Pike County, Illinois		15. CITIZEN OF WHAT COUNTRY? U. S.	
13a. FATHER'S NAME William R. Reeves		13b. MOTHER'S MAIDEN NAME Synthia A. Westfall		14. NAME OF HUSBAND OR WIFE Kathrine Reeves			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Kathrine Reeves - Grant City, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 3 years	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Arteriosclerosis, generalized					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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.					
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)		4500	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 May 1 , 19 52 , to Jan 3 , 19 55 , that I last saw the deceased alive on Jan 3 , 19 55 , and that death occurred at 8a m., from the causes and on the date stated above.							
23a. SIGNATURE Frank B. Matteson MD		23b. ADDRESS Grant City, Mo.		23c. DATE SIGNED 1-5-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan. 5, 1955		24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery		24d. LOCATION (City, town, or county) (State) Albany, Missouri	
DATE REC'D BY LOCAL REG. 1-21-1955		REGISTRAR'S SIGNATURE Letta E. Dawson		25. FUNERAL DIRECTOR'S SIGNATURE Bill A. Dunfee		ADDRESS Grant City, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

1210

1130

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 Bill A. Dwyer

Licensed Embalmer No. 4908

P. O. Address Grant City, 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.