

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25491

State File No. ....

FILED AUG. 30 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 227

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pattis</u>	
b. CITY OR TOWN <u>Fulton</u>	c. LENGTH OF STAY (In this place) <u>1Y-11M2D</u>	c. CITY OR TOWN <u>Sedalia</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #1</u>		e. STREET ADDRESS (If rural, give location) <u>0804</u>	

3. NAME OF DECEASED (Type or Print) <u>Beryl</u>	a. (First)	b. (Middle) <u>McReynolds</u>	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 23 1955</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>Married</u>	8. DATE OF BIRTH <u>Sept 29 1892</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>24</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		

13a. FATHER'S NAME <u>Horace Johnston</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>unknown</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>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>State Hospital Records, Fulton, Mo.</u>	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>		
	ANTECEDENT CAUSES DUE TO (b) <u>Cerebral Hemorrhage</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 <u>331X.</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)	21e. INJURY OCCURRED WHILE AT 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 Aug 7 1955 to Aug 23 1955, that I last saw the deceased alive on Aug 22 1955, and that death occurred at 9:40 A.M. from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title)	23b. ADDRESS <u>State Hospital, Fulton, Mo.</u>	23c. DATE SIGNED <u>8/23/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug-25-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>
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DATE REC'D BY LOCAL REG. <u>Aug-23-1955</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Sedalia Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

REC'D 1951

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 *D. W. Heckart*

Licensed Embalmer No. *341*  
P. O. Address *Sedalia*

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.