

FILED FEB 13 1957

## STANDARD CERTIFICATE OF DEATH

3442

STATE FILE NUMBER

Registration District No. 352 Primary Registration District No. 6187 Registrar's No. 16

1. PLACE OF DEATH a. COUNTY <u>Taney</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Taney</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cedar Creek</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Cedar Creek</u> <u>1060</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>home Cedar Creek</u>		Length of stay in lb <u>15 yrs</u>	d. STREET ADDRESS <u>Cedar Creek</u> (If outside, give location) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>CHARLES BRYON REGER</u> First Middle Last			4. DATE OF DEATH <u>Jan. 28 1957</u> Month Day Year		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1908</u>	9. AGE (In years last birthday) <u>48</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gilbert Reger</u>			14. MOTHER'S MAIDEN NAME <u>Alice Cox</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>189-40-4451</u>	17. INFORMANT <u>Gertrude Reger, Cedar Creek, Mo</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myelogenous Leukemia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2041</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Nov 1955</u> to <u>Jan 1957</u> and last saw her/him alive on <u>Jan 21, 1957</u> Death occurred at <u>8:00 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>James T Gard MD</u>			22b. ADDRESS <u>Springfield, Mo</u>		22c. DATE SIGNED <u>2-2-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>1-30-1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ozark Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Branson Mo</u>	
24. FUNERAL DIRECTOR <u>Sanford Funeral Home</u> ADDRESS <u>Sanford Mo</u>		25. DATE RECD. BY LOCAL REG. <u>2-5-57</u>		26. REGISTRAR'S SIGNATURE <u>Walter Campbell</u>	

(Licensed Embalmer's Statement on Reverse Side)

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Doctor, coroner, etc. must use only standard nomenclature in item 10. No symptoms or diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *Walter S Cobb* \_\_\_\_\_

Licensed Embalmer No. *47*

P. O. Address *Forney*

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.