

FILED DEC 9 - 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 283

S. 300  
v. 1-57 D

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Fulton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Callaway Mem. Hosp.</b>			Length of stay in 1b <b>10 days</b>		d. STREET ADDRESS (If outside, give location) <b>214 W. 9th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Georgia</b> Middle <b>Elizabeth</b> Last <b>Reynolds</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>3</b> Year <b>1957</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 2, 1883</b>		9. AGE (In years last birthday) <b>74</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital attendant</b>		11. BIRTHPLACE (City and state or country) <b>Callaway County Mo. USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13a. FATHER'S NAME <b>James Priest</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Knight</b>		14. NAME OF HUSBAND OR WIFE <b>Ed. Reynolds</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Mrs. Effie Winscott Fulton Mo.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure &amp; Cardiac Renal vascular dysfunction</b> DUE TO (b) <b>Essential hypertension</b> DUE TO (c) <b>Cerebral arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>442X</b>						
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 <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 Death occurred at <b>6/3/57 4/1/57 to 12/3/57 2:00 p.m.</b> on the date stated above; and last saw her alive on <b>12/3/57</b> .								
22a. SIGNATURE (Degree or title) <b>George T. Woodruff</b>				22b. ADDRESS <b>Fulton Mo.</b>		22c. DATE SIGNED <b>12/7/57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/6/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Middle River</b>		23d. LOCATION (City, town, or county) (State) <b>Callaway County Mo.</b>		
24. FUNERAL DIRECTOR <b>Maney D. H. Fulton Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Dec. 7-1957</b>		26. REGISTRAR'S SIGNATURE <b>Martha Lawrence</b>		

(Licensed Embalmer's Statement on Reverse Side)

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FEB 3 1959

MS FEB 1 1959

APR 3 1959

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 J. J. Ross .....

Licensed Embalmer No. 2555

P. O. Address Aurora, Ill.

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.