

Health,  
& Welfare  
S. Public  
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iv. 1-56

Securing the medical certificate in the special manner required by 193.140 MoRS 1949.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED DEC 23 1957

44170

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 5514 Registrar's No. 671

<b>1. PLACE OF DEATH</b> a. COUNTY <b>HENRY</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b>		b. COUNTY <b>HENRY</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>OSAGE TWP.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>DEEPWATER RT 2</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DEEPWATER RT.2</b>		Length of stay in lb <b>85Yrs</b>		d. STREET ADDRESS <b>OSAGE TWP.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>WILLIAM D. REESE</b>		First <b>WILLIAM D.</b>		Middle <b>REESE</b>	
Last <b>REESE</b>		<b>4. DATE OF DEATH</b> Month <b>DEC. 16th</b>		Day <b>1957</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <b>APRIL 28th 1907</b>		9. AGE (In years last birthday) <b>90</b>		IF UNDER 1 YEAR Month <b>7</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (City and state or country) <b>WALES</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>W. D. REESE</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>LEE REESE DEEPWATER, MO. RT.2</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>		Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>Generalized arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>4200</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.) <b>4200</b>			
20c. TIME OF INJURY Hour 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 <b>DEEPWATER</b>		COUNTY <b>HENRY</b>	
STATE <b>MISSOURI</b>		21. I attended the deceased from <b>1946</b> to <b>Feb 56</b> and last saw her alive on <b>Feb. 1956</b> Death occurred at <b>106 S. Third St.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Frances D. Smith</i>		22b. ADDRESS <b>106 S. Third St.</b>		22c. DATE SIGNED <b>12/16/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12/18/57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MAPLEWOOD</b>	
23d. LOCATION (City, town, or county) <b>BROWNINGTON, MO.</b>		23e. STATE <b>MISSOURI</b>		24. FUNERAL DIRECTOR <b>SCHABERG FUNERAL HOME</b>	
ADDRESS <b>CLINTON, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>12-19-57</b>		26. REGISTRAR'S SIGNATURE <i>Mildred Bigum</i>	

(Licensed Embalmer's Statement on Reverse Side)

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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 F. L. Schiberg

Licensed Embalmer No. 451

P. O. Address Clinton

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.