

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**46930**

STATE FILE NUMBER

**FILED JAN 6 1958**

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 250

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Saline</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>414 N. Conway</u> Length of stay in lb <u>3 days</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u> c. CITY OR TOWN <u>Marshall</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET (If outside, give location) ADDRESS <u>R.R. 3, Marshall, Mo.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James (Jim)</u> Middle <u>-----</u> Last <u>Reynolds</u>				<b>4. DATE OF DEATH</b> Month <u>December</u> Day <u>26</u> Year <u>57</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro.</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>December 20, 1874</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> Address <u>Mrs. Annie Reynolds, Marshall, Missouri</u>					
<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) <u>Respiratory Failure, Acute</u> (b) <u>Pulmonary Embolus</u> (c) <u>Hypertrophy of Heart</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Heart Disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>  <u>(years)</u>	
<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SCULDS</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour <u>10:45</u> a. m. <u>p. m.</u> Month, Day, Year		<b>20d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
<b>20e. PLACE OF INJURY</b> (e. g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>			
<b>21. I attended the deceased from</b> <u>Birth</u> <b>to</b> <u>Dec 30 - 57</u> <b>and last saw him alive on</b> <u>Dec 30 - 57</u> <b>Death occurred at</b> <u>10:45 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.</u>									
<b>22a. SIGNATURE</b> (Degree or title) <u>C. L. Lawless M.D. Coroner Saline Co.</u>				<b>22b. ADDRESS</b> <u>Mrs. Hall Mo</u>		<b>22c. DATE SIGNED</b> <u>12-30-57</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>12/31/57</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fairview Cemetery</u>		<b>23d. LOCATION (City, town, or county) (State)</b> <u>Marshall, Missouri</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Georgette Green Marshall Mo.</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>12-31-57</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Carl G. Reed</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service

300  
1-56

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. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FEB 13 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 .....

Licensed Embalmer No. 422

P. O. Address Marshall

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.