

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB-11 1958

1687
STATE FILE NUMBER

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>J</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Serington</u>		Inside Limits <u>0542</u> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McCune-Brooks</u>		Length of stay in 1b <u>6 hrs</u>	d. STREET ADDRESS <u>218 S. 9th</u> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ernel</u> Middle <u>E.</u> Last <u>Reeves, Jr.</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13, 1934</u>	9. AGE (In years last birthday) <u>23</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Serington, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Ernel E. Reeves, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes 1954-1957</u>		16. SOCIAL SECURITY NO. <u>486-36-6611</u>		17. INFORMANT Address <u>Mrs Lauren Mackie Smithville, Mo.</u>	
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>Acute Respiratory Failure, Shock</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Contusions laceration of brain</u>			
		DUE TO (c) <u>Head injury, Probable skull fracture</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple lacerations, fracture of humerus</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Automobile collision on highway -</u>		
20c. TIME OF INJURY Hour <u>10</u> a. m. <u>1</u> p. m. Month, Day, Year <u>1 19 58</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. CITY, TOWN, OR LOCATION <u>Avilla</u> COUNTY <u>Jasper</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>1-19-58</u> to <u>1-19-58</u> and last saw her alive on <u>1-19-58</u> Death occurred at <u>4:30 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W Russell Smith, MD.</u> (Degree or title)			22b. ADDRESS <u>Carthage, Mo.</u>		22c. DATE SIGNED <u>1-20-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Jan. 20, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mc Phelia</u>		23d. LOCATION (City, town, or county) (State) <u>Serington Mo.</u>
24. FUNERAL DIRECTOR <u>Ulmer Funeral Home, Carthage, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Jan 20, 1958</u>		26. REGISTRAR'S SIGNATURE <u>W. Clenton</u>	

(Licensed Embalmer's Statement on Reverse Side)

Date Filed
County File Number
FEB 10 1958

FEB 13 1958

MAR 28 1958

APR 1 1958

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.....
[Handwritten Signature]

Licensed Embalmer No.

P. O. Address.....
[Handwritten Address]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.