

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2266

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 66

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u>		c. CITY OR TOWN <u>Marshall, R.R. 3</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sedalia Rest Home</u>		d. STREET ADDRESS <u>R.R. 3</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Reynolds</u> Last <u>Reynolds</u>		4. DATE OF DEATH Month <u>12</u> Day <u>6</u> Year <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>	
13. FATHER'S NAME <u>John Gates</u>		14. MOTHER'S MAIDEN NAME <u>Christene Gates</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Josephine Thompson</u>		Address <u>Marshall 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>GASTRIC HEMORRHAGE</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>PEPTIC ULCERS</u> DUE TO (c) <u>5400</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. UREMIA, - 2. JUVENILE PSYCHOSIS</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 <u>4:45</u> Month <u>Nov</u> Day <u>5</u> Year <u>58</u> a. m. <u>PM</u> 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 <u>NOV 5-57</u> to <u>DEATH</u> and last saw <u>her</u> alive on <u>JAN-6-58</u> Death occurred at <u>4:45 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Rail B. Gower MD</u>		22b. ADDRESS <u>Sedalia Mo</u>	
22c. DATE SIGNED <u>7-JAN-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>12-9-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grainview</u>	23d. LOCATION (City, town, or county) (State) <u>Marshall, Missouri</u>
24. FUNERAL DIRECTOR <u>Ernest Green</u>		25. DATE RECD. BY LOCAL REG. <u>1-7-58</u>	
ADDRESS <u>Marshall Mo</u>		26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health,  
Welfare  
Public  
Service300  
1-56

All diseases in Part I must be causally related. Coroner must certify to a death due to natural causes. 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 must certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1959 FEB 6

DEC 15 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.....

Licensed Embalmer No. 42

P. O. 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.