

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018742

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 58

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fort Leonard Wood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Whitestown</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>Range # 10</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>813 E 8</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Worrell</u> Last <u>Reynolds</u>			4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 Jan 1924</u>	9. AGE (In years last birthday) <u>35</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>	11. BIRTHPLACE (City and state or country) <u>Zionsville, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Deceased</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Joan Reynolds</u>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>4 Oct 1945 to Pres.</u>	16. SOCIAL SECURITY NO. <u>311-20-1178</u>	17. INFORMANT <u>Bernard S Wysocki, US Army Hosp, Ft Wood, Mo.</u>
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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>Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Multiple Wounds, Neck, Chest and Abdomen</u>	
	DUE TO (c) <u>Hand Grenade Fragments</u> <u>9198</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>43</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>Exploding Hand Grenade</u>
20c. TIME OF INJURY Hour <u>11:00</u> a.m. <u>PM</u> Month <u>May</u> Day <u>13</u> , Year <u>59</u>	

20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) <u>Range # 10</u>	20f. CITY, TOWN, OR LOCATION <u>Fort Leonard Wood</u>	COUNTY <u>Pulaski</u>	STATE <u>Missouri</u>
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21. I estimate the deceased died on May 13, 1959 at 11:00 o'clock, PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Harold N. Baruch, Capt, MC</u>	22b. ADDRESS <u>US Army Hospital Fort Leonard Wood, Missouri</u>	22c. DATE SIGNED <u>13 May 59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>May 14, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Unknown Indiana</u>	23d. LOCATION (City, town, or county) (State) <u>Lebanon, Boone Co, Indiana</u>
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24. FUNERAL DIRECTOR <u>Hedges</u> ADDRESS <u>HELDG'S FUNERAL HOMES INC CROCKER MO</u>	25. DATE RECD. BY LOCAL REG. <u>5-15-59</u>	26. REGISTRAR'S SIGNATURE <u>Gula Grace Anderson</u>
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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

MEDICAL CERTIFICATION

5. 300
1-57

FILED MAY 21 1959

1959 JUN 6

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 *Clarence Cross*

Licensed Embalmer No. *4896*
P. O. Address *Waynesville, N.C.*

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.