

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 8 1959

59-028770

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 923

1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b <u>D.O.A.</u>		c. CITY OR TOWN <u>Stratford</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A. St. Johns Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Route 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>Olive</u> Last <u>Reaves</u>						4. DATE OF DEATH Month <u>August</u> Day <u>30</u> , Year <u>1959</u>							
5. SEX <u>Female</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>7-25-1903</u>		9. AGE (last birthday) <u>56</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done or profession if retired) <u>Machine operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture Mfg.</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>					
13a. FATHER'S NAME <u>William Denton Walker</u>				13b. MOTHER'S MAIDEN NAME <u>Nora Viola Ellingsworth</u>				14. NAME OF HUSBAND OR WIFE <u>Berl Reaves</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>No</u> or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. _____				17. INFORMANT Address <u>Berl Reaves--Stratford, 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>Presumed to be natural causes</u> (Coroner of Greene county notified) DUE TO (b) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 _____ Month, Day, Year _____ 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 _____ COUNTY _____ STATE _____						
21. I attended the deceased <u>her</u> and last saw <u>him</u> alive on _____ Death occurred at <u>5:30 h.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Effie G. Melton - Local Registrar Greene Co, Springfield, Mo</u>						22b. ADDRESS _____				22c. DATE SIGNED <u>8-31-59</u>			
23a. BURIAL OR CREMATION, METHOD (Specify) <u>Burial</u>		23b. DATE <u>9-1-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>						
24. FUNERAL DIRECTOR ADDRESS <u>Rex Rainey Springfield, Mo.</u>					25. DATE RECD. BY LOCAL REG. <u>8-31-59</u>			26. REGISTRAR'S SIGNATURE <u>Effie G. Melton</u>					

IDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 10 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
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 337

P. O. Address: _____

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