

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036527

FILED VS NOV 4 1959 / 46

Registration District No. _____ Primary Registration District No. **3026** Registrar's No. **471**

STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 613 North Kiger Independence Mo		Length of stay in lb 1 week	c. CITY OR TOWN Bates City Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Taylor Last Reynolds			4. DATE OF DEATH Month Oct. Day 29 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1884	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Osceola Mo.	12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Elijah Reynolds		13b. MOTHER'S MAIDEN NAME Susan Elizabeth Robinson		14. NAME OF HUSBAND OR WIFE Ida Belle		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 492-18-5228	17. INFORMANT Floyd Reynolds Address Bates City Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH 12 Hrs.	
IMMEDIATE CAUSE (a) Hypostatic Pneumonia					3 Months	
DUE TO (b) Coronary Thrombosis					Years	
DUE TO (c) Arteriosclerosis						
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 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 _____ a.m. _____ p.m. Month, Day, Year _____						
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 from Oct. 26, 1959 10 A.M. to Oct. 29, 1959 and last saw her alive on Oct. 29, 1959 him Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>W. R. ...</i>			22b. ADDRESS Independence, Mo.		22c. DATE SIGNED Oct. 30,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Nov. 1, 1959	23c. NAME OF CEMETERY OR CREMATORY Lowry City Cemetery		23d. LOCATION (City, town, or county) Lowry City Mo.	(State)	
24. FUNERAL DIRECTOR Husman-sparks ADDRESS Odessa, Mo		25. DATE RECD. BY LOCAL REG. 10-30-59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 17 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 William T. [Signature]

Licensed Embalmer No. # 44

P. O. Address Osles

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.