

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-039834

FILED VS. DEC 7 1959 140

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 3024 Registrar's No. 107

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| 1. PLACE OF DEATH<br>a. COUNTY <b>Howard</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Fayette</b>                |  | Length of stay in 1b<br><b>56 days</b>  | c. CITY OR TOWN <b>Fayette</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Lee Hospital</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>304 North Vine</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print)<br>First <b>Effie</b> Middle <b>Plains</b> Last <b>Reynolds</b> | 4. DATE OF DEATH<br>Month <b>December</b> Day <b>4</b> Year <b>1959</b> |
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|                         |                                  |   |                                       |                                     |   |  |
|-------------------------|----------------------------------|---|---------------------------------------|-------------------------------------|---|--|
| 5. SEX<br><b>Female</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/26/1891</b> | 9. AGE (last birthday)<br><b>68</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
|-------------------------|----------------------------------|---|---------------------------------------|-------------------------------------|---|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> | 11. BIRTHPLACE (City and state or country)<br><b>Howard Co. Mo.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b> |
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| 13a. FATHER'S NAME<br><b>William C. Plains</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Lillie Mae Miller</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Robert Guy Reynolds</b> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT<br><b>Robert Guy Reynolds Fayette Mo.</b><br>Address _____ |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>  |
| IMMEDIATE CAUSE (a)   | <b>Cerebral Embolus</b>                 |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | <b>Chronic Arteriosclerosis 10 yrs.</b> |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Hemiplegia - 15 yrs</b> |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED?<br>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.)<br><b>Hemiplegia - 15 yrs</b> |
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| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>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<br><b>Fayette Mo</b> | COUNTY _____ STATE _____ |
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| 21. I attended the deceased from <b>1-1-1957</b> to <b>Dec-4-1959</b> and last saw him alive on <b>12-4-59</b><br>Death occurred at <b>7:05 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |
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| 22a. SIGNATURE<br><b>wa Bloom M.D.</b> (Degree or title) | 22b. ADDRESS<br><b>Fayette Mo</b> | 22c. DATE SIGNED<br><b>12-5-59</b> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>12/6/59</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fayette City Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Fayette Missouri</b> |
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| 24. FUNERAL DIRECTOR<br><b>Ralph A Cur Fayette, Mo.</b> ADDRESS _____ | 25. DATE RECD. BY LOCAL REG.<br><b>12-5-59</b> | 26. REGISTRAR'S SIGNATURE<br><b>Katherine Welch</b> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 17 1959

JAN 6 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

~~only~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Ralph A. Case

Licensed Embalmer No. 3340

P. O. Address Jayette, La

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.