

FILED VS NOV 17 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-043123

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 228

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>VERNON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>VERNON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>NEVADA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>SHELDON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>FANNING REST HOME</b>		Length of stay in 1b <b>2 YR</b>	d. STREET ADDRESS (If outside, give location) <b>1088 0</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ETTA</b> Middle <b>REITOW</b> Last			4. DATE OF DEATH Month <b>NOV</b> Day <b>5</b> Year <b>1959</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>0</b>	11. BIRTHPLACE (City and state or country) <b>HAMILTON MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>RUFUS MASON</b>		13b. MOTHER'S MAIDEN NAME <b>LETTIE BROOKS</b>		14. NAME OF HUSBAND OR WIFE <b>OTTO REITOW</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>X</b>		Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Probable cerebral embolism</b>					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Fractured Right hip</b>					<b>6 da.</b>
DUE TO (c) <b>9030</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>20</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>Slipped and fell</b>			
20c. TIME OF INJURY Hour <input checked="" type="checkbox"/> a.m. <input checked="" type="checkbox"/> p.m. <b>9-29-58</b>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. CITY, TOWN, OR LOCATION <b>Nevada</b>		20g. COUNTY STATE <b>Vernon Mo</b>	
21. I attended the deceased from <b>10-1-59</b> to <b>11-5-59</b> and last saw her alive on <b>11/1/59</b> Death occurred at <b>11/35</b> p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>James J. Pascoe M.D.</b>			22b. ADDRESS <b>Nevada Mo</b>		22c. DATE SIGNED <b>Nov-10-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>NOV 9, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SHELDON CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>SHELDON MO</b>	
24. FUNERAL DIRECTOR <b>BEENEY FUNERAL HOME</b>		ADDRESS <b>SHELDON MO</b>	25. DATE RECD. BY LOCAL REG. <b>Nov-13-1959</b>	26. REGISTRAR'S SIGNATURE <b>Anna &amp; Jerry</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
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.

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 *J. Bernard Benez* .....

Licensed Embalmer No. *4161* .....

P. O. Address *Holden Mo* .....

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.