

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005931

INDEXED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 274 STATE FILE NUMBER

1. PLACE OF DEATH
 a. COUNTY Greene
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield Length of stay in 1b 15yrs.
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital Inside Limits Yes No
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo' b. COUNTY Greene
 c. CITY OR TOWN Springfield Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 1925 N Washington St. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First RICH Middle D Last REYNOLDS
4. DATE OF DEATH Month March Day 2 Year 1960

5. SEX Male **6. COLOR OR RACE** Negro **7. Married** Never Married Widowed Divorced
8. DATE OF BIRTH April 16 1894 **9. AGE (last birthday)** 65 **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) R.R. Employee **10b. KIND OF BUSINESS OR INDUSTRY** Frisco R.R. **11. BIRTHPLACE** (City and state or country) Chapel Hill, Tenn' **12. CITIZEN OF WHAT COUNTRY** USA

13a. FATHER'S NAME Tom Reynolds **13b. MOTHER'S MAIDEN NAME** Nancey McCoy **14. NAME OF HUSBAND OR WIFE** Julia Reynolds

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.** **17. INFORMANT** Julia Reynolds 1925 N Washington 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) Ruptured dissecting aortic & iliac artery aneurysm **INTERVAL BETWEEN ONSET AND DEATH** 7 - abdominal day
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)

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.** Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO **20a. ACCIDENT** **SUICIDE** **HOMICIDE** **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 NOT WHILE AT WORK **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 2-20-60 to 3-2-60 and last saw him alive on 3-2-60
 Death occurred at 9:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE SB Lemmond (Degree or title) **22b. ADDRESS** Springfield, Mo **22c. DATE SIGNED** 3-4-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial **23b. DATE** March 8 1960 **23c. NAME OF CEMETERY OR CREMATORY** Hazlewood **23d. LOCATION** (City, town, or county) Springfield (State) Mo'

24. FUNERAL DIRECTOR H.V. Smith ADDRESS 620 N Jefferson St. **25. DATE RECD. BY LOCAL REG.** 3-4-60 **26. REGISTRAR'S SIGNATURE** Effie S. Melton

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 5 1961

1961

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 Herbert V Smith

Licensed Embalmer No. 4280

P. O. Address Springfield

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.