MO DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS AUG 29 1960
Dr. Clark

60-030274
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 885

1. PLACE OF DEATH
a. COUNTY GREENE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD — Length of stay in 1b: 40 YRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. DE CHANTEL ACADEMY — Inside Limits Yes ☐ X No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY GREENE
c. CITY OR TOWN SPRINGFIELD — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) ST DE CHANTEL ACADEMY — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First SISTER Middle MARY Last JAMES REARDON
4. DATE OF DEATH: Month AUG. Day 22 Year 1960
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married X Widowed ☐ Divorced ☐
8. DATE OF BIRTH: JUNE 1876
9. AGE (last birthday): 84 — 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): NUN
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): ST. LOUIS, MO.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: JOHN REARDON
13b. MOTHER'S MAIDEN NAME: MARY O'NEIL
14. NAME OF HUSBAND OR WIFE: X
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NO
17. INFORMANT: ACADEMY RECORDS. Address: SPRINGFIELD, MO.

MEDICAL CERTIFICATION

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
IMMEDIATE CAUSE (a)	Bronchial Pneumonia	48 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Carcinomatosis	1 yr
DUE TO (c)	Carcinoma of Colon	1 yr

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 10-25-58, to 8-20-58 and last saw her/him alive on 8-20-60
Death occurred at 1 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Michael J. Clark (Degree or title)
22b. ADDRESS 1636 S. Glenstone
22c. DATE SIGNED 8-23-60

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 8/23/60
23c. NAME OF CEMETERY OR CREMATORY: ELFINDALE CEMETERY
23d. LOCATION (City, town, or county) (State): SPRINGFIELD, MO.

24. FUNERAL DIRECTOR ADDRESS: H.H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.
25. DATE RECD. BY LOCAL REG.: 8-26-60
26. REGISTRAR'S SIGNATURE: Effie G. Mellon

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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