

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.
3065-X ^A ①

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

61 08 MAY 30 1929

PLACE OF DEATH
County Randolph
City Cairo

Registration District No. 329
Primary Registration District No. 3963

File No. _____
Registered No. 1
St. _____ Ward _____

2. FULL NAME Amanda Reynolds
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 8th 1858
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
70 | 9 | 23
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Mo
10. NAME OF FATHER Larkin Reynolds
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) ky
12. MAIDEN NAME OF MOTHER Polly Page
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) ky

14. INFORMANT Chas. Reynolds
(Address) R F D Cairo
15. FILED Jan 10 1929 J. P. Allen
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 11th 1929
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 3:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary atherosclerosis
sinus & stroke
18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH, _____
19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) John P. Allen, M. D.
Boine (Address) 1-2nd, 1929

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IF NOT AT PLACE OF DEATH, _____
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(Signed) John P. Allen, M. D.
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*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Liberty DATE OF BURIAL 1-2nd 1929
20. UNDERTAKER Mahon and Son ADDRESS Boine Mo

John P. Allen
