APR 24 1929

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

Do not use this space.

9813

1. PLACE OF DEATH
County: Cape Girardeau
Registration District No.: 124
Primary Registration District No.: 4010
File No.:
Registered No.: 21
Township: Byrd
City: Jackson (No. ..... St. ..... Ward)

2. FULL NAME: Emma Bernice Reynolds

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	white	Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Grabiel Reynolds

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 2 1860

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	68	4	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(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): New Wells Mo.

PARENTS

10. NAME OF FATHER: Pennod

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Not Known

14. INFORMANT: H. S. Reynold
(Address): Jackson Mo.

15. FILED: 3-20, 1929 D. G. Suber
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mch 20 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1929, to Mch 20, 1929, that I last saw h. alive on after Feb 15, 1929, and that death occurred, on the date stated above, at 12:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of liver and intestines
U.S.
Hours (duration) Dur Run yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): none
Hours (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Dur Run

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) D. G. Suber, M. D.
3-20, 1929 (Address) Jackson Mo

*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	DATE OF BURIAL
Allen Cemetery	Mar 21 1929

20. UNDERTAKER	ADDRESS
McCombs Funeral Home Co	Jackson Mo

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.

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