

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

26140
 Do not use this space.

1. PLACE OF DEATH Linn 2
 (a) County Brookfield Registration District No. 496
 (b) Township Brookfield Primary Registration District No. 3025 Registered No. 69
 (c) City Brookfield (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 711 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Gertrude Ellen Reynolds
 (a) Residence, No. Brookfield Mo St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-13 1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William J. Reynolds

22. I HEREBY CERTIFY, That I attended deceased from 6-14 1939, to 7-13 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 29, 1868

I last saw her alive on 7-13 1939... Death is said to have occurred on the date stated above, at 110.09 a.m.

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>71</u>	<u>3</u>	<u>14</u>		

The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Date of onset _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brookfield Mo.

Other contributory causes of importance:
Strong tubercular heart
Strong stenosis - 946
Arteriosclerosis - 6210

FATHER 13. NAME Melvin W. Dewey

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York State

Name of operation _____ Date of _____

MOTHER 15. MAIDEN NAME Phoebe Jane Tubbs

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York State

What test confirmed diagnosis? Cert Was there an autopsy? No

17. INFORMANT (ADDRESS) Don Reynolds
Brookfield Mo.

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? 0 Date of injury 0, 19____
 Where did injury occur? 0 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL PLACE Rose Hill DATE July 15 1939

Manner of injury 0
 Nature of injury 0

19. FUNERAL DIRECTOR (NAME) John D. Rusak
 (ADDRESS) Marceline Mo

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) James H. Brown, M. D.
 (Address) Brookfield, Mo

20. FILED Aug 1 1939 Spoutlaugh
 Local Registrar.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

58
1
2

RECEIVED

District Health Office No. 111

District File Number

839-935

Date Filed

AUG 2 1939

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

John D. Rusk

Licensed Embalmer No. 3805

P. O. Address Marceline 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 this body is not embalmed, above space should be left blank.