

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 16 1940

State File No. _____
Registrar's No. 18

Registration District No. 486

Primary Registration District No. 5649

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.

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Rural Sumners Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) _____
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days _____

3. (a) PRINT FULL NAME Milly Marie Reeves
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
alive _____ years
7. Birth date of deceased July 18 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Lincoln Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Lucas Taylor
13. Birthplace Elkhart Mo
(City, town, or county) (State or foreign country)
14. Maiden name Mary Lucy Reeves
15. Birthplace Lincoln Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Milly Reeves
(b) Address Elkhart Mo
17. (a) Rural (b) Date thereof 7/28/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Thompson Cem

18. (a) Signature of funeral director W. R. Adley
(b) Address Elkhart Mo
19. (a) 8-10-40 (b) Eda Powell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lincoln
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. Rural (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
year 1940 hour _____ minute 12:30 P. M.
21. I hereby certify that I attended the deceased from July 23
_____, 1940, to July 23, 1940
that I last saw her alive on July 23, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Heart Disease
Duration _____

Due to _____
Due to _____

Other conditions Obstructive Jaundice
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature J. Hallaway (M.D. or other) MD
Address Elkhart Mo Date signed 7/24/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.