

SEP 5 1940  
Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Warsaw  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: General Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution General Hosp.  
(Specify whether  
In this community Unknown  
years, months or days)

3. (a) PRINT FULL NAME William Reeves 170

3. (b) If veteran, name war Unk. 3. (c) Social Security No. Unk.

4. Sex male 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 Unknown 1854  
(Month) (Day) (Year)

8. AGE: Years 66 Months - Days - If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Do not know 9  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name Do not know  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant W. J. Callaway  
(b) Address Green St.

17. (a) Buried (b) Date thereof Aug 19 40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Panama Bros  
(b) Address W. C. Me

19. (a) Aug. 19, 1940 (b) M-M. Crave  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
(c) City or town Warsaw  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2 West 9th Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I examined the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ give on \_\_\_\_\_, 19\_\_\_\_;  
and that \_\_\_\_\_ the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due Chronic Myocarditis  
Due to 92 or 1-

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on (such, in industrial place, in public place)? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify time of day) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature W. J. Callaway (M. D. or other)  
Address W. C. Me Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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..... *Park Rowe*

Licensed Embalmer No. *2347*

P. O. Address *12 CMO*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**