No. 2
4-13-40
-17-39
I X23159

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED OCT 12 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31304

Registration District No. 30 Primary Registration District No. 3003 Registrar's No. 48

1. PLACE OF DEATH:
(a) County Barry
(b) City or town Monett
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 110 Maple St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Barry
(c) City or town Monett
(If outside city or town limits, write "RURAL")
(d) Street No. 110 Maple St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Reba Jane West
3. (b) If veteran, name war
3. (c) Social Security No. None
4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Carl West
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Apr. 26, 1910 (Month) (Day) (Year)
8. AGE: Years 30 Months 4 Days 7 If less than one day hr. min.
9. Birthplace Springdale (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name W. T. Johnson
13. Birthplace Missouri (City, town, or county) (State or foreign country)
14. Maiden name Georgiana Bohanan
15. Birthplace Madison Co., Ark. (City, town, or county) (State or foreign country)
16. (a) Informant E. S. Yerton,
(b) Address 110 Maple St., Monett, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation I. O. O. F. Cemetery
18. (a) Signature of funeral director Leallaway
(b) Address Monett, Mo.
19. (a) 9-5-1940 (Date received local registrar) (b) W. M. West (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3 year 1940 hour 4 minute 15 M.P.
21. I hereby certify that I attended the deceased from July 21, 1940, to Sept 3, 1940, that I last saw her alive on Sept 3, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Streptococcus Septicemia	7/15/40
Due to: Pelvic Peritonitis and Endometritis	7/1/40
Due to: abortion induced medically - Lamicella instrumentally	Sept 6/20/40
Other conditions (Include pregnancy within 3 months of death): Retained destructive endometritis	

Major findings: Of operations: Pus in blood cultures short + long chain Streptococci
Of autopsy: Not Performed

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Dr. Kenneth L. Kelley (M. D. or other) D.O.
Address 16 E. Lawrence St. Aurora, Mo. Date signed 8/3/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1040—2699
Date Filed OCT 11 1940 OCT 11 1940

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 J. W. Buchanan, Registered Apprentice No. ..... working under my personal supervision.

Signed J. W. Buchanan

Licensed Embalmer No. 3179

P. O. Address Monett Mo

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

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