

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

22569

Do not use this space.

1. F. OF DEATH

() County St. Francois Registration District No. 774

(b) Township St. Francois Primary Registration District No. 446.5 Registered No. 1047

(c) City Flat River mo Street No. 1 St.

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

2. PRINT FULL NAME Clva Reagan

(a) Residence, No. 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

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF R.O. Reagan

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 12th 1876

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>64</u>	<u>10</u>	<u>14</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HWY

9. Industry or business in which work was done, as saw mill, bank, etc. at home

10. Date deceased last worked at this occupation (month and year) 6/26/41

11. Total time (years) spent in this occupation 44

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) near Marquand mo

FATHER

13. NAME W.R. Matthews

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Senon

MOTHER

15. MAIDEN NAME Catherine Howard

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison mo

17. INFORMANT (ADDRESS) R.O. Reagan
Marquand mo

18. BURIAL, CREMATION, OR REMOVAL Reverend Chapel
Marquand mo DATE 6-26, 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Baldwell Bros
Flat River mo

20. FILED 7/3, 1941 C. B. Hester mo
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-26, 1941

22. I HEREBY CERTIFY, That I attended deceased from 6-24, 1941, to 6-26, 1941.

I last saw her alive on 6-26, 1941. Death is said to have occurred on the date stated above, at 12:20 P.M.

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

Coronary Occlusion Date of onset

Other contributory causes of importance: 94 W

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. Death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify.....

(Signed) C. B. Hester, M. D.

(Address) Flat River mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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 X14023

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22569

Registration District No. 774

Primary Registration District No. 4465

Registrar's No. 1047

1. PLACE OF DEATH:

(a) County St. Francis
(b) City or town _____
(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 Ova Reagan

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased (Month) (Day) (Year) _____

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country) _____

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country) _____

16. (a) Informant's own signature _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year) _____
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12/14 (b) C. Blarner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Includes pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____

Of autopsy _____

Duration

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) (c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's name and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X1951

S-22569

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.