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FILED OCT 16 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

32366

State File No.

Registration District No. 744

Primary Registration District No. 3035

Registrar's No. 87

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Richmond
(If outside city or town limits, write "RURAL", and name of township)

(c) Name of hospital or institution:
Cunningham Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
In this community all life / (Specify whether years, months or days)

3. (a) PRINT FULL NAME THOMAS B. REAVIS

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

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lennie Henderson 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased June 8th, 1860
(Month) (Day) (Year)

8. AGE: Years 81 Months 3 Days 10
If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business.....

12. Name Thomas B. Reavis

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

14. Maiden name Harriett Duffett
(City, town, or county) (State or foreign country)

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

16. (a) Informant Lennie Henderson Reavis

(b) Address Richmond, Missouri

17. (a) Burial (b) Date thereof Sept. 20 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richmond, Missouri

18. (a) Signature of funeral director [Signature]

(b) Address Richmond, Missouri

19. (a) Sept 25-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray 029

(c) City or town Richmond
(If outside city or town limits, write "RURAL.")

(d) Street No. Cunningham Street
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country D

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 18th
year 1941 hour 5:10 minute A.M.

21. I hereby certify that I attended the deceased from 41 Sept 1941 to 41 Sept 1941
that I last saw alive on Sept 18 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Duration 4 1/2

Due to arterio-sclerosis

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings: Of operations 430

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?.....

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

23. Signature [Signature] (M. D. or other)
Address [Signature] Date signed Sept 22-41

965 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-14-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by ~~max~~
....., Registered Apprentice No.
working under my personal supervision.

Signed *E. H. Harrison*

Licensed Embalmer No. 2073

P. O. Address Richmond, Mo.

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

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