

Registration District No. **163**

Primary Registration District No. **5596**

1. PLACE OF DEATH:

(a) County **Jefferson**
(b) City or town **Rural VALLE**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Rout 2, DeSoto
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None**
In this community **1 month - 19 Days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jefferson**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route 2, DeSoto**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Robert Joseph Reando**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Infant**
6. (b) Name of husband or wife **Infant** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Jan. 22, 1944**
(Month) (Day) (Year)

8. AGE: Years ********* Months **10** Days **19** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Infant**

11. Industry or business _____

MOTHER FATHER { 12. Name **Raymond Reando**
13. Birthplace **Washington Co. Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Rachel Christopher**
15. Birthplace **Washington Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Raymond Reando**

(b) Address **R.R. #2 DeSoto**

17. (a) **Burial** (b) Date thereof **March 12, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **DeSoto MO. (Calvary)**

18. (a) Signature of funeral director **Lee Mothershead**

(b) Address **DeSoto, Mo.**

19. (a) **3-13-44** (b) **Jern Spencer**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **11**
year **1944** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **March 7th**, 19**44**, to **March 11**, 19**44**
that I last saw him alive on **March 10**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** Duration _____
Pneumonia

Due to **Pneumonia**

Due to **Pneumonia**
Pneumonia

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

Major findings: Of operations **ZZA** PHYSICIAN _____
Of autopsy _____ 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.A. Elders** (M. D. or other) **MD**
Address **DeSoto Mo** Date signed **3/12/44**

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

509

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-27-44

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 J. J. McChesney
Licensed Embalmer No. 353
P. O. Address: Des Moines, Ia

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, fact should be so stated above.