DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 20175

Registration District No. FILED JUL 15 1944 818 Primary Registration District No. 1003

Registrar's No. 6107

**1. PLACE OF DEATH:**

(a) County

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

(c) Name of hospital or institution: Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since April 24, 1944 (Specify whether years, months or days)

In this community Since April 24, 1944.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Nebraska (b) County 999

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

(d) Street No. 624 Fulton (If rural, give location) NR

(e) Citizen of foreign country? (Yes or No)

If yes, name country I

3. (a) PRINT FULL NAME John Benjamin Reynolds

3. (b) If veteran, name war No.

3. (c) Social Security No. 702-14-0515

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Florence Fay Lemon

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased June 16, 1883 (Month) (Day) (Year)

8. AGE: Years 61 Months 0 Days 23 If less than one day hr. min.

9. Birthplace Rockport, Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation Telegrapher,

11. Industry or business Mo. Pac. R. R. Co.

MOTHER FATHER

12. Name Wm. R. Reynolds,

13. Birthplace Mo. (City, town, or county) 0 (State or foreign country)

MOTHER

14. Maiden name Griscia Caroline Settles

15. Birthplace Greenville, Tenn. (City, town, or county) I (State or foreign country)

16. (a) Informant Florence F. Reynolds,

(b) Address Falls City, Nebraska

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/10/44 (Month) (Day) (Year)

(c) Place: burial or cremation Hoxie, Kansas

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

19. (a) JUL 10 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 9 year 1944 hour 1 minute 40 A.M.

21. I hereby certify that I attended the deceased from April 24, 194 to July 9, 194; that I last saw him alive on July 9, 194; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Malignancy - metastasis | |
| Due to: Hypernephroma Rt Kidney | |
| Due to: | |
| Other conditions (Includes pregnancy within 3 months of death): None. | |

Major findings:
Of operations NONE

Of autopsy Hypernephroma Rt. Kidney

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 E. P. Scott M.D. (M. D. or other)

Address 1755 S. Grand Ave. Date signed 7-9-44

Mo E. P. Scott

(Licensed Embalmer's Statement on Reverse Side)

## 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. 1994

P. O. Address.....

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

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