

FILED NOV 28 1944

Registration District No. 13

Primary Registration District No. 3003

Registrar's No. 74

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: St. Vincent's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days  
In this community over 50 years  
years, months or days (Specify whether)

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. 416 Lincoln Ave  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Susan Courdin Reynard

3. (b) If veteran, name war none  
3. (c) Social Security No. none

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

(b) Name of husband or wife James John Reynard 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased May 25 1874  
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 3 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace: Uruguay, S. America  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Stephen Courdin

13. Birthplace Piedmont Valley, Italy  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Condon

15. Birthplace Piedmont Valley, Italy  
(City, town, or county) (State or foreign country)

16. (a) Informant James J. Reynard

(b) Address 416 Lincoln, Monett, Mo

17. (a) Burial (b) Date thereof Oct. 30, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Waldensian Cemetery, Monett, Mo

18. (a) Signature of funeral director Ballaway

(b) Address Monett, Missouri

19. (a) Oct 30 1944 (b) Audna Mullaughley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 28  
year 1944 hour 9 minute 5 A.M.

21. I hereby certify that I attended the deceased from Oct 23  
1944 to Oct 28 1944

that I last saw her alive on Oct 27 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Branchiopneumonia Duration 2 days

Due to Myocardial degeneration & Chronic pericarditis ?

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_ (Specify type of injury)  
23. Signature Frank Peters (M. D. or other)  
Address Monett, Mo Date signed 10/28/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

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

MOTHER, FATHER

RECEIVED

District Health Officer No. 6;

District File Number 1144-1250

Date Filed NOV 24 1944

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. D. 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 with the above constitutes grounds for revocation of license.)

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

Registration District No. 13 Primary Registration District No. 3003

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:  
(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 Susan C. Reynaud

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 m

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased May 25  
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days \_\_\_\_\_  
If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

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 \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12 year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to Chronic hepatitis?  
arteriosclerotic kidney?

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)

(e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

1944  
S-37045