V. S. No. 2
50M—5-42
Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 1 1945

Registration District No. 128

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Langston

State File No. 6161

Primary Registration District No. 2000

Registrar's No. 126

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: City Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Hours (Specify whether
In this community 4 Months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Sac

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

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

(e) Citizen of foreign country? 2 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME James Harlan Reynolds

3. (b) If veteran, name war UNK.

3. (c) Social Security No. UNK.

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased Jan. (Month) 27 (Day) 1869 (Year)

8. AGE: Years 76 Months 0 Days 15 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name James Reynolds
13. Birthplace UNK. (City, town, or county) Ohio (State or foreign country)

MOTHER
14. Maiden name Elizabeth McCashin
15. Birthplace UNK. (City, town, or county) Ohio (State or foreign country)

16. (a) Informant R. E. Davis
(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/45 (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director H. H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 2-14-45 (Date received local registrar) (b) S. W. Z. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 12
year 1945 hour 12 minute 20 a. M.

21. I hereby certify that I attended the deceased from 2-11, 1945, to 2-12, 1945
that I last saw him alive on 2-11, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Skull Fracture — Duration hours.

Due to automobile accident

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

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) Accident

(b) Date of occurrence 2/11/45

(c) Where did injury occur? Springfield (City or town) Greene (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? public place - South Ave at Mt. Vernon (Specify type of place)

While at work? No (e) Means of injury automobile

23. Signature W. Roland Langston (M. D. or other) M.D.

Address Springfield, Mo. Date signed 2/12/45

(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 L Dorlin Forman

Licensed Embalmer No. 3177

P. O. Address Springfield 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.

X