S. No. 2
0M—2-43
v. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 9 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

10033

State File No.

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 13

1. PLACE OF DEATH:
(a) County: Lafayette
(b) City or town: Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 815 Franklin
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community: 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Lafayette
(c) City or town: Lexington, Mo 4
(If outside city or town limits, write "RURAL")
(d) Street No.: 815 Franklin 3
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 2
If yes, name country: 0

3. (a) PRINT FULL NAME: LUTHER H. REAVIS
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: Ma 1
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Alice Anderson
6. (c) Age of husband or wife if alive: 55 years
7. Birth date of deceased: May (Month) 10 (Day) 1866 (Year)
8. AGE: Years 78 Months 10 Days 16 If less than one day hr. min.
9. Birthplace: Osceola (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Coal Miner
11. Industry or business:
FATHER 12. Name: Wm Reavis 1
FATHER 13. Birthplace: (City, town, or county) Va 1 (State or foreign country)
MOTHER 14. Maiden name: Not Known 9
MOTHER 15. Birthplace: Not Known 9 (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Alice Reavis
(b) Address: Lexington, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-28-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Lexington, Mo
18. (a) Signature of funeral director: Gerard A Tempel
(b) Address: Lexington, Mo
19. (a) April 4-45 (Date received local registrar) (b) Mrs. H. Schwab (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 26 year 1945 hour 5 minute A M.
21. I hereby certify that I attended the deceased from Jan 8, 1945, to Mar 26, 1945; that I last saw him alive on Mar 25, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Infected Nephrit — Duration: and years
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death): Ex hem chronic Arth
Gut atrens sclerosis
Major findings:
Of operations:
Of autopsy: 1/2/0

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: [illegible] (M. D. ~~coroner~~)
Address: Lexington Mo Date signed: 3/26/45

1158

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
RECEIVED
District Health Officer No. 8
Date Filed
District File Number
Date Filed 4/6/42

Explan

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 Geo. McKean

Licensed Embalmer No. 2983

P. O. Address Lexington, 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.