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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Glynn

State File No. 30598

FILED OCT 8 1945

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 773

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: Spfd. Baptist Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Months (Specify whether

In this community 2 Months years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 30

(c) City or town Rural Clay Township (If outside city or town limits, write "RURAL")

(d) Street No. Route # 3 Springfield, Mo. (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Cleo B. Reynolds

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Luther Reynolds

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased July (Month) 3 (Day) 1910 (Year)

8. AGE: Years 35 Months 2 Days 25 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Chas. Beshears
13. Birthplace Galloway (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Maude Joyce
15. Birthplace Galloway (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Luther Reynolds

(b) Address Galloway, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/45 (Month) (Day) (Year)

(c) Place: burial or cremation Galloway, Mo.

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 10-3-45 (Date received local registrar) (b) H W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 28 year 1945 hour 12 minute 40p. M.

21. I hereby certify that I attended the deceased from Dec 25 1944, to Sept 28 1945; that I last saw her alive on Sept 28 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Urinary septicaemia	
Due to Peritonitis spreading	9 mo
Due to Appendicitis acute perforated	12/25/44
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations: Acute spreading peritonitis with perforated appendix

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)

(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 Robert Glynn (M. D. or other) M.D.

Address Springfield, Mo. Date signed 10/3/45

984

(Licensed Embalmer's Statement on Reverse Side)

OCT 20 1953

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 Walter E. Hamilla

Licensed Embalmer No. 3808

P. O. Address Springfield Me

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.