

No. 2
-542
-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6780**

FILED FEB 28 1948

Registration District No. **292**

Primary Registration District No. **6002**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Ralls**
(b) City or town **(Rural) Saltriver Township**
(c) Name of hospital or institution:
Perry, Missouri R.F.D.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community **65 Yrs.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ralls**
(c) City or town **Perry, Missouri R.F.D.**
(If outside city or town limits, write "RURAL")
(d) Street No. **(Rural) Saltriver Township**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **John Nichols Reager.**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **None.**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Nov. 24, 1846**
(Month) (Day) (Year)

8. AGE: Years **99** Months **1** Days **7** If less than one day hr. _____ min. _____

9. Birthplace **Marion County, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer.**

11. Industry or business **Farm.**

12. Name **Absolam Reager.**

13. Birthplace **Unknown Virginia**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Davis.**

15. Birthplace **Unknown Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ruby Jacobs**
(b) Address **Perry, Missouri.**

17. (a) **Burial** (b) Date thereof **Jan. 1, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Lickcreek Cemetery, Perry, Mo.**

18. (a) Signature of funeral director **Clyde Wilkey**

(b) Address **Perry, Missouri.**

19. (a) **1-1-48** (b) **Clyde Wilkey**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **31**
year **1948** hour **10:00** minute **A.M.**

21. I hereby certify that I attended the deceased from **Dec 17** 1948 to **Dec 31** 1948
that I last saw him alive on **Dec 21** 1948
and that death occurred on the date and hour stated above.

Immediate cause of death **P. I. I.**

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations **336**
Of autopsy _____

Duration **2 wks.**

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 **John E. Brown** (M. D. or other) _____
Address **Perry, Mo.** Date signed **1/1/48**

267

(Licensed Embalmer's Statement on Reverse Side)

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

101034

RECEIVED

Dist. Health Officer No. 10

2-46-289

Date Filed FEB 25 1946

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, by

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 3820

P. O. Address. Perry, 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. 292 Primary Registration District No. 6002

1. PLACE OF DEATH:
(a) County Ralls
(b) City or town Rural Salt River Mo.
(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 John N. Reager
3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 24 1899
(Month) (Day) (Year)

8. AGE: Years 99 Months _____ Days _____ (if less than one day) _____ hr. _____ min.

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

10. Usual occupation _____
11. Industry or business _____

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 11/46 (b) Clydes Wilsey
(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 Dec Year 1994 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
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) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

PHYSICIAN
Underline the cause to which death should be charged statistically.

0780