

Registration District No. 1 Primary Registration District No. 3-400-5004 Registrar's No. 89

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Novinger
(c) Name of hospital or institution:
R. R. # 1 /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
Life (Specify whether
years, months or days)

3. (a) PRINT FULL NAME George H. Reese
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. Married
6. (b) Name of husband or wife. Minnie Hamilton Reese
6. (c) Age of husband or wife if alive. 55 years
7. Birth date of deceased. June 30 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 8 14 hr. min.

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

10. Usual occupation farmer

11. Industry or business Farming

MOTHER FATHER {
12. Name Peter Reese
13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Shoop
15. Birthplace Unknown Penn.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Minnie Reese
(b) Address Novinger, Missouri

17. (a) Burial (b) Date thereof 3/17/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cmt.

18. (a) Signature of funeral director D. W. Wiley
(b) Address Kirksville, Mo.

19. (a) 3-21-46 (b) I. Tate Lambert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Novinger
(If outside city or town limits, write "RURAL")
(d) Street No. R. R. #1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mch. day 14
year 1946 hour 9:00 minute A M.

21. I hereby certify that I attended the deceased from March 13, 1946 to March 14, 1946
that I last saw him alive on March 13, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Nephritis
Chronic Venous
Due to Heart Disease
Duration 5 yrs
5 yrs

Other conditions. ✓
(Include pregnancy within 3 months of death)

Major findings: ✓
Of operations 13/14
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?
While at work? (Specify type of place) (e) Means of injury

23. Signature N. D. Garrison MD (M. D. or other)
Address Novinger Mo Date signed 3-15-46

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

10993

AUG 22 1945

RECEIVED
District Health Officer No. 10
District File Number 4-46-81
Date Filed APR 19 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, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

D. E. Riley

Licensed Embalmer No.

4141

P. O. Address

Kokomo 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.