

S. No. 2  
DOM-2-43  
ev. 5-17-39  
X35697

33999

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED NOV 12 1948

Registration District No. 170

Primary Registration District No. 4264

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Conway  
(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 years, months or days)

In this community entire life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Laclede

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

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

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Martha Icephene Reser

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Aug day 3  
year 1946 hour 80 minute 07 P.M.

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife Dr. J. H. Reser

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

7. Birth date of deceased Dec 25 1864  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7-1 1946 to 8-3 1946  
that I last saw him alive on 8-3 1946  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>81</u>	<u>7</u>	<u>8</u>	hr. _____ min/

Immediate cause of death Hemorrhage of brain

Due to Hypertension

Due to \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

MOTHER FATHER

12. Name Dr. Z. L. Slavens

13. Birthplace unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Irene Stanley

15. Birthplace unknown  
(City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Gladys Reser

(b) Address Conway Mo.

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? \_\_\_\_\_

(c) Place: burial or cremation Conway Cemetery

18. (a) Signature of funeral director W. E. Holman

(b) Address Lebanon Mo.

19. (a) Oct 30, 1946 (b) Dr. Frankburger  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Dr. Lindsey (M. D. or other) MD  
Address Conway Date signed 8-6-46

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

32826

Received 11-8-46

Laclede County Health Unit

File No. 8-46-146

Date Filed 11-9-46

---

---

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 Dorsey M Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon 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.