

S. No. 2
OM-8-43
v. 5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 20 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1467

Registration District No. 150

Primary Registration District No. 4239

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Lee's Summit
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
612 Miller Street /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 20 Years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Lee's Summit Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 612 Miller Street
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Corb E. Reeves

3. (b) If veteran, name war No

3. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8
year 1947 hour 3:50 minute _____ A.M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Lyman Reeves

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased May 16 1870
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 2 1946 to Jan 8 1947
that I last saw her alive on Jan 8 1947
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>7</u>	<u>22</u>	hr. _____ min.

Immediate cause of death
Congestive Heart Failure

Due to Cardio-Vascular-Renal Disease

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

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

10. Usual occupation Home

Major findings:
Of operations _____

Of autopsy _____

13/A

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

11. Industry or business |||||

12. Name John D. Taylor

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

14. Maiden name Elizabeth Malott

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

16. (a) Informant Clyde Bagby

(b) Address Liberty 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? _____

17. (a) Burial (b) Date thereof 1/10/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lee's Summit Mo.

18. (c) Signature of funeral director H. B. Langford

(b) Address Lee's Summit Mo.

19. (a) JAN. 9, 1947 (b) Donald C. Embelaw
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(a) Means of injury _____

23. Signature Clara Miller (M. D. or Ch. M. D.)
Address Lee's Summit Mo. Date signed 1/9/47

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

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(Licensed Embalmer's Statement on Reverse Side)

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

N. B. Langford

Licensed Embalmer No. 3833

P. O. Address Lee Summit, 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.