

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Bloomfield
(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 _____
In this community Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
(c) City or town Bloomfield, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dr. William A. Reynolds

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 Mrs. Natlie Reynolds 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 9, 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 8 12 hr. min.

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

10. Usual occupation Dentist

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 H. L. Reynolds

(b) Address Clarkton, Mo.

17. (a) Emial (b) Date thereof Mar. 23, 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marble Hill, Mo.

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) 3-28-47 (b) Rose Welber
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 21st
year 1947 hour 10:40 minute A. M.

21. I hereby certify that I attended the deceased from March 17, 1947 to March 21, 1947
that I last saw him alive on March 21, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 5 days

Due to Coronary Occlusion

Due to _____
Other conditions (Include pregnancy within 3 months of death) 94%

Major findings: Of operations None Performed
Of autopsy None Performed
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 0

23. Signature St. Louis (M. D. or other) MD

Address Bloomfield Mo. Date signed 3-27-1947

FATHER {
MOTHER {

RECEIVED
District Health Officer No. 2,
District File Number 447-478
Date Filed 4-3-47

1967 E
J311

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 L. L. Lull
Cooper, Registered Apprentice No. _____
working under my personal supervision.

Signed Juan B. Cooper
Licensed Embalmer No. 4119
P. O. Address Bloomfield, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)
If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 338

Primary Registration District No. 4501

Registrar's No. _____

1. PLACE OF DEATH

(a) County Stoddard
(b) City or town Blomfield, 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

William A Reynolds

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 _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____

(Month) (Day) (Year)

8. AGE:

Years Months Days (Less than one day)
71 _____ hr. _____ min.

9. Birthplace _____

(City, town, or county) (State or foreign country) Va

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Rose T. Huber
(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 _____
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings:

Of operations _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

B
S
3880

S-1240