

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. **38676**FILED DEC 9 1946  
Registration District No. **19A36**Primary Registration District No. **2004**

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

## 1. PLACE OF DEATH:

(a) County **Jasper**  
 (b) City or town **Joplin**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **Home**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **44 Years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Mildred L. Reynolds**

3. (b) If veteran, name war. \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Fe** / 5. Color or race **W**  
 6. (a) Single, widowed, married, divorced **Married**  
 6. (b) Name of husband or wife **B. F. Reynolds**  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **2** (Month) **8** (Day) **1884** (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>63</b>	<b>8</b>	<b>3</b>	_____ hr. _____ min.

9. Birthplace **Iowa**  
(City, town, or county) (State or foreign country)10. Usual occupation **house duty**

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. F. Reynolds**(b) Address **2129 Harlem**17. (a) **Burial** (b) Date thereof **10/14/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Ozark Memorial**18. (a) Signature of funeral director **Hurlbut Montuary**(b) Address **212 Joplin St.**19. (a) **10-14-47** (b) **Sabara Lampkin**  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper** **49**  
 (c) City or town **Joplin** **2**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **2129 Harlem Ave.** **5**  
 (If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No) **1**  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **11**  
year **1947** hour **12:30** minute **P** M.

21. I hereby certify that I attended the deceased from **five** 19**47** to **Oct 11** 19**47**  
 that I last saw her alive on **Oct 8** 19**47**  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

**Pulmonary Tuberculosis** **3 yrs (?)**

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations **30**

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

## PHYSICIAN

Underline the cause of 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) (s) Means of injury \_\_\_\_\_

23. Signature **Ernest Mitchell** (M. D. or other) **0**Address **Joplin Mo.** Date signed **10-13-47**

MOTHER FATHER

## 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 \_\_\_\_\_

Licensed Embalmer No. 909

P. O. Address \_\_\_\_\_

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. see

Registration District No. 156

Primary Registration District No. 204

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

1. PLACE OF DEATH:

(a) County Jasper  
 (b) City or town Joplin  
(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

Mildred L. Reynolds

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased Feb 8  
(Month) (Day) (Year)

8. AGE: Years 63 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) \_\_\_\_\_ (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) \_\_\_\_\_  
(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 \_\_\_\_\_, 19\_\_\_\_; 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 \_\_\_\_\_

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 \_\_\_\_\_

MOTHER FATHER

**SUPPLEMENTARY**

PHYSICIAN

Underline the cause to which death should be charged statistically.

38676