

No. 2
5-43
5-17-39
X38671

FILED APR 16 1948

Registration District No. **299**

Primary Registration District No. **6027**

Registrar's No. **8**

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

1. PLACE OF DEATH:
 (a) County Reynolds
 (b) City or town Reynolds
(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)

3. (a) PRINT FULL NAME Leas Bounds
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 Widowed
6. (b) Name of husband or wife Lavinia Bounds
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 20 1866
(Month) (Day) (Year)

8. AGE: Years 81 Months 6 Days 15
If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER

12. Name Marion Bounds

13. Birthplace Iron Mountain MO
(City, town or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Paris Bounds

(b) Address Centerville MO

17. (a) Buried **(b) Date thereof** 2-7-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Turner Graveyard near Nat. Rd.

18. (a) Signature of funeral director Leisel

(b) Address Centerville MO

19. (a) 3/10/48 **(b)** C. M. T. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Reynolds
 (c) City or town Reynolds
(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 Feb day 5 year 1948 hour 7 minute P M.
21. I hereby certify that I attended the deceased from unattended to _____ 1948
 that I last saw him alive on about 1-70 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death Cortic regurgitation
 Duration 5 yrs

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? _____
(Specify type of place)
 While at work? _____ (e) Means of injury _____
23. Signature C. M. T. [Signature] (M. D. or other) MO
Address Centerville MO **Date signed** 2/25/48

RECEIVED

District:

Case No. 5,
448255

District File

Date Filed

4-13-48

5-9846

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.....

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. May
Registrar's No. 8

Registration District No. 299 Primary Registration District No. 6027

1. PLACE OF DEATH

(a) County Reynolds
(b) City or town Reynolds
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Isaac Beards

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 wid

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

7. Birth date of deceased July 20
(Month) (Day) (Year)

8. AGE: Years 81 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country) 1/7/48

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) _____
(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 _____ Day _____
year _____ hour _____ minute _____ M.

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

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

S-13729