

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**FILED JAN 18 1954**

State File No. **296**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **41**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>DeKalb</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Union Star</b> <b>0820</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Methodist Hosp.</b>		d. STREET ADDRESS (If rural, give location) <b>/</b>	

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Elda</b> b. (Middle) <b>Marl</b> c. (Last) <b>Reynolds</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Jan. 13, 54</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>married</b>	<b>8. DATE OF BIRTH</b> <b>Feb. 16, 1876</b>	<b>9. AGE</b> (In years last birthday) <b>77</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Physician</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>M.D.</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>Marion Co. Iowa</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>

<b>13a. FATHER'S NAME</b> <b>A.C.Reynolds</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Hanna Jane Teter</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Norah Reynolds</b>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <b>Norah Reynolds Union Star, Missouri</b>

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>15 days</b>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Coronary ael</b>		
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. <b>DUE TO (b) Heart dis art scler</b> <b>DUE TO (c)</b>		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <b>4 days status pneumonia</b>		<b>4 days</b>	
<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>4201</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)	<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>

**22. I hereby certify that I attended the deceased from 12-28, 1953, to 1-13, 1954, that I last saw the deceased alive on 1-13, 1954, and that death occurred at 7:30 p. m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or title) <b>Dr. J. J. Johnson M.D.</b>	<b>23b. ADDRESS</b> <b>St. Joseph, Mo.</b>	<b>23c. DATE SIGNED</b> <b>1-13-54</b>
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>24b. DATE</b> <b>Jan. 17, 54</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Union Star</b>
		<b>24d. LOCATION</b> (City, town, or county) (State) <b>Union Star, Missouri</b>

<b>DATE REC'D BY LOCAL REG.</b> <b>Jan 16, 1954</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Bethen M. Allison</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Roland D. Clark</b>	<b>ADDRESS</b> <b>King City, Mo</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

300  
48

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Roland D. Clark

Licensed Embalmer No. 4477

P. O. Address King City, 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.