

**STANDARD CERTIFICATE OF DEATH**

State File No. **7473**  
 Registrar's No. **17**

BIRTH NO. **FILED FEB 16 1954** REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074**

1. PLACE OF DEATH a. COUNTY <b>Scott</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>Scott</b>	
b. CITY OR TOWN <b>Sikeston</b>		c. CITY OR TOWN <b>Sikeston</b> <span style="float:right">1003 0</span>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Scott Co. Bldg - Center St.</b>		d. STREET ADDRESS (If rural, give location) <b>534 N. RANNEY</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>HAROLD</b>	b. (Middle) <b>EUGENE</b>	c. (Last) <b>REUBER</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>2-8-1954</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-3-1895</b>	9. AGE (In years last birthday) <b>58</b>	if UNDER 1 YEAR Months <b>4</b>	if UNDER 24 HRS. Days <b>5</b>	if UNDER 1 MIN. Hours	if UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Osteo. Phy.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>OSTEO. WITH.</b>	11. BIRTHPLACE (State or foreign country) <b>PRESTON MINN.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13a. FATHER'S NAME <b>JOHN REUBER</b>	13b. MOTHER'S MAIDEN NAME <b>MARY KLEIMENHAGEN</b>	14. NAME OF HUSBAND OR WIFE <b>HELEN</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, do not know) <b>YES</b>	(If yes, give war or date of service) <b>WWI</b>	16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Helen Reuber Sikeston Mo.</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 min</b>	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Upper respiratory infection</b>			<b>2 days</b>
	DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>5272</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **4:30 pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Helena C. Bickthorpe, M.D. Health Officer</b>	23b. ADDRESS <b>Benton, Mo.</b>	23c. DATE SIGNED <b>2-11-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>2-11-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>GARDEN OF MEMORIES</b>	24d. LOCATION (City, town, or county) (State) <b>Sikeston - Mo.</b>
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DATE REC'D BY LOCAL REG. <b>2-13-54</b>	REGISTRAR'S SIGNATURE <b>Mrs. Ella Hunter</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Funeral Home</b>	ADDRESS <b>Sikeston, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300  
10.48

FEB 23 1914

*1000*

**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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address. Sitesteron 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.