

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31248**

FILED OCT 15 1954

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043** Registrar's No. **3029**

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

| | | | |
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| 1. PLACE OF DEATH a. COUNTY Marion | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Marion | |
| b. CITY (If outside corporate limits, write RURAL and give township) Hannibal | | c. CITY OR TOWN Hannibal | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) | | e. STREET ADDRESS (If rural, give location) 306 North Seventh | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Levering Hospital | | | |

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|---|------------|-------------|-----------|--|
| 3. NAME OF DECEASED (Type or Print) Winnie Carver Reynolds | a. (First) | b. (Middle) | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year) October 3, 1954 |
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|----------------------|-------------------------------|---|---|---|--|---|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH December 17, 1872 | 9. AGE (In years last birthday) 81 | IF UNDER 1 YEAR Months 9 Days 16 | IF UNDER 24 HRS. Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XX Invalid | 10b. KIND OF BUSINESS OR INDUSTRY Invalid | 11. BIRTHPLACE (City and State or Foreign Country) Keokuk Iowa | 12. CITIZEN OF WHAT COUNTRY? U S A |
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| 13a. FATHER'S NAME No record | 13b. MOTHER'S MAIDEN NAME No record | 14. NAME OF HUSBAND OR WIFE Franklin Edward Reynolds |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) None | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Miss Leolia Reynolds | ADDRESS Hannibal Missouri |
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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, asthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 1 year |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Recurrent Cell Laxoma | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) amebiasis DUE TO (c) psittacosis | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? 2000 YES <input type="checkbox"/> NO <input 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) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from **Aug 7, 1954**, to **Oct 3, 1954**, that I last saw the deceased alive on **Oct 3, 1954**, and that death occurred at **2:25 A. m.**, from the causes and on the date stated above.

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|---|----------------------------------|---------------------------------|
| 23a. SIGNATURE Robert Lanning MD (Degree or title) | 23b. ADDRESS Hannibal, Mo | 23c. DATE SIGNED 10/3/54 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 10/6/54 | 24c. NAME OF CEMETERY OR CREMATORY Grand View Burial Park | 24d. LOCATION (City, town, or county) (State) Hannibal Missouri |
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| DATE REC'D BY LOCAL REG. 10-7-54 | REGISTRAR'S SIGNATURE Dr. E. M. Lucke | 25. UNLAWFUL DIRECTOR'S SIGNATURE W. T. Fisher | ADDRESS Hannibal Missouri |
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RECEIVED OCT 13 1954
MARION CO. HEALTH DEPT.
DATE FILED OCT 13 1954

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.....
Signature of Student Embalmer

Signed *John J. Kord*.....
Licensed Embalmer No....4540..

P. O. Address Hannibal, Missouri

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.