

FILED DEC 10 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38772

STATE FILE NUMBER

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 421

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, give TOWNSHIP only) OR TOWN Hannibal		c. CITY OR TOWN Hannibal	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering Hospital		d. STREET ADDRESS (If outside, give location) 1109 Fulton Avenue	
3. NAME OF DECEASED (Type or print) First ROY F Middle REYNOLDS Last		4. DATE OF DEATH November 30, 1956 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1884
9a. USUAL OCCUPATION (One kind of work done during most of working life, even if retired) Molder, Retired		9b. AGE (In years last birthday) 72	10. KIND OF BUSINESS OR INDUSTRY Roodhouse Illinois
11. BIRTHPLACE (City and state or country) Roodhouse Illinois		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME W. W. Reynolds		14. MOTHER'S MAIDEN NAME Emily Frances Devore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 490 07 7859	
17. INFORMANT Miss Leolia Reynolds		Address Hannibal Missouri	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 11-16-56 to 11-30-56 and last saw her alive on 11-30-56 Death occurred at 8:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M J Miller M.D.</u> (Degree or title)		22b. ADDRESS Hannibal Mo	
22c. DATE SIGNED Dec 3/56			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 12/3/1956	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet		23d. LOCATION (City, town, or county) Hannibal Missouri (State)	
24. FUNERAL DIRECTOR <u>H. J. ...</u> ADDRESS Hannibal Missouri		25. DATE RECD. BY LOCAL REG. 12/6/56	
26. REGISTRAR'S SIGNATURE <u>N. M. Lucke R. J. ...</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED DEC 7 1958
MARION CO. HEALTH DEPT.
DATE FILED DEC 7 1958

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 S. Ward*.....

Licensed Embalmer No...454

P. O. Address Hannibal, Mi

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.