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I.R. Johnson

FILED JAN 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44769

BIRTH NO. _____ REG. DIST. NO. 272 PRIMARY REG. DIST. NO. 5908 Registrar's No. 3

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

1. PLACE OF DEATH
a. COUNTY Pemiscott
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hermondale
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo. b. COUNTY Pemiscott
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hermondale
d. STREET ADDRESS (If rural, give location) 0180

3. NAME OF DECEASED (Type or Print) a. (First) Herman b. (Middle) Leander c. (Last) Reynolds

4. DATE OF DEATH (Month) (Day) (Year) 6-12-1956

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 5-18-1875

9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Male

10b. KIND OF BUSINESS OR INDUSTRY White

11. BIRTHPLACE (State or foreign country) Nova Scotia Canada 2

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE Mrs. Roe Ellis Reynolds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME Mrs Roe Reynolds ADDRESS

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinosis — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Carcinoma of rectum — 2 years.

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 154X

20. AUTOPSY? 2 YES ☐ NO ☑

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-16, 1956, *to* 6-12-56, 19__, *that I last saw the deceased alive on* 6-12-56, 19__, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD

23b. ADDRESS Blytheville, Ark.

23c. DATE SIGNED 6-14-56

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 6-13-1956

24c. NAME OF CEMETERY OR CREMATORY Mt. Zion

24d. LOCATION (City, town, or county) (State) Steele Mo.

DATE REC'D BY LOCAL REG. 6-17-62

REGISTRAR'S SIGNATURE [signature]

25. FUNERAL DIRECTOR'S SIGNATURE [signature] ADDRESS Blytheville Ark.

(Licensed Embalmer's Statement on Reverse Side)

1-15-57

JAN 21 1957

PEMISCOT COUNTY HEALTH DEPARTMENT
COURTHOUSE PHONE 79
CARUTHERSVILLE, MO.

JUN 18 1957

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.