

Health, Welfare, Public Service

300-56

Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4237

STATE FILE NUMBER

FILED FEB 27 1957

Registration District No. 114 Primary Registration District No. 4186 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>FRANKLIN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SULLIVAN</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>SULLIVAN</u>		0361 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>42 S. OLIVE</u>		Length of stay in lb <u>8 Mo.</u>		d. STREET ADDRESS (If outside, give location) <u>42 S. OLIVE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>L</u> Last <u>REEVES</u>			4. DATE OF DEATH Month <u>FEB</u> Day <u>20</u> Year <u>1957</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 2, 1907</u>	9. AGE (In years last birthday) <u>49</u>	IF UNDER 1 YEAR Month <u>5</u> Day <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE IND.</u>		11. BIRTHPLACE (City and state or country) <u>BOURBON, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN REEVES</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIA BOYER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>493-01-1339</u>		17. INFORMANT Address <u>MARIE REEVES SULLIVAN, MO.</u>			
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>ACUTE CORONARY THROMBOSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 HR.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>				3 YEARS	
DUE TO (c) _____							
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.) <u>4201</u>				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>SEPT 1953</u> to <u>FEB. 20-1957</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>FEB 20-1957</u> Death occurred at <u>2:50 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Robert J. Crawford Jr. Sullivan, Missouri</u>				22b. ADDRESS		22c. DATE SIGNED <u>Feb 21, 1957</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<u>BURIAL</u>		<u>FEB. 22, 1957</u>	<u>V.O.O.F. MEMORIAL CEM.</u>		<u>SULLIVAN MO.</u>		
24. FUNERAL DIRECTOR <u>H. Sullivan</u>		ADDRESS <u>Sullivan, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>2/21/57</u>	26. REGISTRAR'S SIGNATURE <u>Thomas G. Humphrey</u>		

(Licensed Embalmer's Statement on Reverse Side)

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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 *J. R. Humphrey*.....

Licensed Embalmer No. 477

P. O. Address *Sullivan,*

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.