

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39004

FILED OCT 24 1957

STATE FILE NUMBER

Registration District No. 378 Primary Registration District No. 4552 Registrar's No. 95

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Wright</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mountain Grove</u>		c. CITY OR TOWN <u>Mountain Grove</u> <u>1141</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		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>608 Oakland Ave</u>		d. STREET ADDRESS (If outside, give location) <u>608 Oakland Avenue</u>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Phoebe</u> Middle <u>Reeves</u> Last <u>Reeves</u>			4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1957</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 17, 1879</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	11. BIRTHPLACE (City and state or country) <u>Salisbury, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John W. Youcum</u>	13b. MOTHER'S MAIDEN NAME <u>Martha R. Bailey</u>	14. NAME OF HUSBAND OR WIFE <u>Ralph Reeves</u>
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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.	17. INFORMANT <u>Mrs Betty Blazer - Marshfield, Missouri</u>
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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>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<u>2</u>
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>
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <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 <u>Mountain Grove, Mo.</u>	COUNTY _____ STATE _____
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21. I attended the deceased from <u>1939</u> to <u>8/21/57</u> and last saw <u>her</u> alive on <u>8/21/57</u> Death occurred at <u>Do not know</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>W.G. Craig D.O.</u>	(Degree or title)	22b. ADDRESS <u>Mountain Grove Mo.</u>	22c. DATE SIGNED <u>10-11-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/2/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Mountain Grove, Missouri</u>
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24. FUNERAL DIRECTOR <u>Barber Funeral Home - Mtn. Grove, Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>10-11-57</u>	26. REGISTRAR'S SIGNATURE
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18-0

RECEIVED 10-11-57
 WRIGHT CO. HEALTH DEPT.
 County File Number 1057-112
 Date Filed 10-28-57

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

Signed *George Steppa*

Signature of Student Embalmer

Licensed Embalmer No. *3161*

P. O. Address *Mr. Brown, W.*

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.