

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014673

FILED VS APR 18 1960

STATE FILE NUMBER

Registration District No. 096 Primary Registration District No. 4158 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dallas</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Buffalo</u>		Length of stay in 1b <u>40 days</u>		c. CITY OR TOWN <u>Buffalo</u>		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>on Locust St.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>on Locust St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>MYRTLE ALEXANDER REYNOLDS</u>				4. DATE OF DEATH Month Day Year <u>April 1 1960</u>									
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>Aug 1888</u>		9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
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>Housework</u>		11. BIRTHPLACE (City and state or country) <u>Louisburg, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Francis Line</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Hughes</u>			14. NAME OF HUSBAND OR WIFE <u>Earl Reynolds (Dec'd)</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>✓</u>		17. INFORMANT Address <u>Jesse Donnell Buffalo Mo.</u>							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
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 a.m. p.m.		Month, Day, Year											
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 <u>1945</u> to <u>4-1-60</u> and last saw her alive on <u>3-31-60</u> Death occurred at <u>4:30 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>C. O. Hammond M.D.</u>				22b. ADDRESS <u>Buffalo, Mo.</u>				22c. DATE SIGNED <u>4-5-60</u>					
23a. BURIAL, CREMATION, REMOVALS (Specify) <u>Burial</u>		23b. DATE <u>April 3-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louisburg Cemetery, Louisburg, Mo.</u>				23d. LOCATION (City, town, or county) (State)					
24. FUNERAL DIRECTOR <u>L. B. Jones Buffalo, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>4/15/60</u>		26. REGISTRAR'S SIGNATURE <u>Mr Vera Petree</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

