No. 2
11-10-39
7-17-39
K21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1923

FILED FEB 11 1942
Registration District No. 1-9 137
Primary Registration District No. 4077
Registrar's No. 1

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

1. PLACE OF DEATH:
(a) County Livingston, Conrad
(b) City or town Hale, Tina (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home of May Smith, Hale, Mo. / (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community 6 years, (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Livingston
(c) City or town Avalon (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? / years.

3. (a) PRINT FULL NAME GETTY ANN REAMES,
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F /
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife A. C. REAMES
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 26th, 1855 (Month) (Day) (Year)

8. AGE: Years 86 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Ohio, / (City, town, or county) (State or foreign country)
10. Usual occupation Housewife,
11. Industry or business

FATHER
12. Name John Cunningham,
13. Birthplace unknown, C (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Deboran Green,
15. Birthplace unknown, G (City, town, or county) (State or foreign country)

16. (a) Informant Chas Cunningham,
(b) Address Avalon, Missouri.
17. (a) Burial, Misso (Burial, cremation, or removal) (b) Date thereof 1/1/1942. (Month) (Day) (Year)
(c) Place: burial or cremation Avalon, Missouri.
18. (a) Signature of funeral director Clifford W. Austin,
(b) Address Tina, Missouri.
19. (a) Jan. 2 1942 (Date received local registrar) (b) Mrs Edgar Smith (Registrar's signature)

1068

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30
year 1941 hour 7 minute P. M.

21. I hereby certify that I attended the deceased from Sept 15-1941, 19..., to Dec 30, 1941; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia	2 day
Due to: Fracture of right Hip	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations NO	
Of autopsy No	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Dec 17
(c) Where did injury occur? Hale (City or town) Carroll (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
(Specify type of place)
While at work? No (e) Means of injury Fall

23. Signature Dr A A Ulsh II (M. D. or other) D-O
Address Hale, Mo Date signed 12/31/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number .....

Date Filed 2-9-42

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.....

....., Registered Apprentice No.....,

working under my personal supervision. Body was not embalmed. The deceased left a reque that she not be embalmed.

Signed Clifford W. Justice

Licensed Embalmer No. 3233

P. O. Address Tina, Missouri

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 this body is not embalmed, above space should be left blank.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1923

Registration District No. 137 Primary Registration District No. 4077 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Hale
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Gebby A. Reames
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Apr (Month) 26 (Day) 1855 (Year)

8. AGE: Years 86 | Months 8 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

FATHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 10
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , 19 ;
that I last saw him alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Fractured Hip	1 WK
Due to from fall	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Dec 22, 1941
(c) Where did injury occur? Hale (City or town) Carroll (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
in home (Specify type of place)
While at work? no (e) Means of injury Fall

23. Signature Dr. A. A. Welch II (M. D. or other) D.O.
Address Hale, Mo Date signed 3-7-42