S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 3 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 36181

Registrar's No. 9814

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3424 Delmar Ave 9
(If rural, give location) 0
(e) Citizen of foreign country? (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME Albert Reynolds
3. (b) If veteran, name war None
3. (c) Social Security No.

4. Sex Male 2
5. Color or race Negro
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife dead
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
About 76			hr. min.

9. Birthplace Greenville, Miss. (City, town, or county) (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
MOTHER FATHER
12. Name Unknown 9
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9
16. (a) Informant Lillian Beard
(b) Address 1302 N. Whittier Street.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/47 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director C. W. Roberts
(b) Address 1416 N. Taylor Ave.
19. (a) OCT 23 1947 (Date received by Registrar) (b) J. F. Brecheen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20 year 1947 hour 4 minute P M.
21. I hereby certify that I attended the deceased from Sept. 23, 1947, to Oct. 20, 1947; that I last saw him alive on Oct. 20, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Metastatic Malignancy	
Primary site -General Intestinal Tract	
Due to	
Due to	
Other conditions Meningo-vascular Lues (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature Oscar L. Daniels (M. D. or other)
Address 2601 N Whittier Date signed 10/22/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed. Fulton E. Culkin

Licensed Embalmer No. 198

P. O. Address St Louis Mo

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, fact should be so stated above.