

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

File No. 10475

FILED APR 12 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2783

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2039	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION MO. PACIFIC HOSP		d. STREET ADDRESS (If rural, give location) 5312 Loughborough	
3. NAME OF DECEASED (Type or Print) a. (First) WALTER b. (Middle) ANAIAH c. (Last) REYNOLDS			4. DATE OF DEATH (Month) (Day) (Year) MAR 23 1952
5. SEX MO	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Oct 14, 1884
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RR Clerk	11. BIRTHPLACE (State or foreign country) St Louis Mo
10b. KIND OF BUSINESS OR INDUSTRY Mfr RR		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Wm Reynolds		13b. MOTHER'S MAIDEN NAME Simpson	14. NAME OF HUSBAND OR WIFE Clara Reynolds
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clara Reynolds 5312 Loughborough
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) NO		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> _____	
21f. HOW DID INJURY OCCUR? _____		332X	
22. I hereby certify that I attended the deceased from 3/15, 1952, to 3/21, 1952, that I last saw the deceased alive on 3/23, 1952, and that death occurred at 3:40 P. M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Clement Sullivan, M.D.		23b. ADDRESS Mrs. Pacific Hospital	
23c. DATE SIGNED 3-24-52			
24a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal		24b. DATE 3/25/52	
24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) Affton Mo.	
DATE REC'D BY LOCAL REG. MAR 25 1952		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS L Ziegenhein & Sons 7027 Gravois	

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

**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 .....  
Student Embalmer

Signed W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 7027 Gravis

**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.