

FILED APR 29 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13999**  
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3469**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Firmin Desloge Hospital</b>		• STREET ADDRESS <b>5301 Page Ave.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) <b>MARY</b>		a. (First) <b>A.</b>		c. (Last) <b>REYNOLDS</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>Apr. 16 1954</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>May 19, 1880</b>		9. AGE (In years last birthday) <b>73</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	

13a. FATHER'S NAME <b>Peter Reynolds</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Brannan</b>		14. NAME OF HUSBAND/OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Margaret M. Considine</b> ADDRESS <b>5351 Sutherland</b>	

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) <b>Pneumonia - type undetermined</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>Arteriosclerotic Heart Dis.</b>		yrs.	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis, Mo.</b>	
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? <b>4200</b>	

22. I hereby certify that I attended the deceased from **4/10/54**, 19**54**, to **4/16/54**, 19**54**, that I last saw the deceased alive on **4/16/54**, 19**54**, and that death occurred at **5:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>R. Ameyera M.D.</b>		23b. ADDRESS <b>539 N. Grand St. Louis Mo</b>		23c. DATE SIGNED <b>4/17/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Apr. 19, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>					

DATE REC'D BY LOCAL REG. <b>APR 19 1954</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Kriegshauser 4228 S. Kingshighway Bl.</b>	
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(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 ..... Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed... *William B. White* .....

Licensed Embalmer No. *429*

P. O. Address *428 N. ...*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.**