

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022129

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No.

318
FILED JUN 13 1963

Primary Registration District No.

1003

Registrar's No.

6032

VS 300
Rev. 4/59

1

2 **3079**

3

4 **1**

5 **1**

6

7 **0**

8 **2**

9

10

11

12 **59-0**

13

DATE AMENDED

2

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

59

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 2 1/2 hours		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hosiptal			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4571a Carter Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Violet Middle O Last Reynolds			4. DATE OF DEATH Month June Day 6 Year 1963		
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-31-1910	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glue Girl		10b. KIND OF BUSINESS OR INDUSTRY Rexall Drug Company		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME William F. Clausen		13b. MOTHER'S MAIDEN NAME Della Flayer	
14. NAME OF HUSBAND OR WIFE Fred F. Reynolds		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of) No			
17. INFORMANT Fred F. Reynolds, 4571a Carter Avenue				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis Carcinoma Rt Breast 6mos 170x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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 2-20-63 to 6-6-63 and last saw her ^{her} alive on 6-6-63 Death occurred at 5:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE John Shaner M.D. (Degree or title)			22b. ADDRESS Northland med. Bldg		22c. DATE SIGNED 6-7-63 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 10, 1963	23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery		23d. LOCATION (City, town, or county) St. Louis County, Missouri (State)
24. FUNERAL DIRECTOR Math Hermann & Son, Inc., 2161 E. Fair Ave St. Louis, Missouri			25. DATE RECD. BY LOCAL REG. JUN 8 1963		26. REGISTRAR'S SIGNATURE Joan Smith M.D.

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

Julius R. Brown

Licensed Embalmer No.

5146

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.