

S. No. 2  
—11-10-39  
v. 5-17-39  
I X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED JUN 25 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

16378

State File No.

Registration District No. 791

Primary Registration District No.

Registrar's No. 3896

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Francis Hospital  
(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

8. (a) PRINT FULL NAME Wright Reynolds

3. (b) If veteran, name war WORLD WAR 8. (c) Social Security No. 702-03-9482

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

6. (b) Name of husband or wife LEONA 6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased MARCH 21 1890  
(Month) (Day) (Year)

8. AGE: Years 51 Months 1 Days 16 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Section Foreman

11. Industry or business R. R.

MOTHER FATHER { 12. Name John REYNOLDS

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

14. Maiden name Mother McVernon

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

16. (a) Informant LEONA REYNOLDS

(b) Address MT. VERNON, Mo.

17. (a) REMOVAL (b) Date thereof 5-8-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation SPRINGFIELD, Mo.

18. (a) Signature of funeral director Albert H. Slappey

(b) Address 4700 Washington

19. (a) MAY 8 1941 (b) J. J. [Signature]  
(Date received for burial) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 53  
(c) City or town Mt. Vernon, Mo.  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 7  
year 1941 hour 11:25 minute P. M.

21. I hereby certify that I attended the deceased from 4-2 1941, to 5-7 1941  
that I last saw him alive on 5-7 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute hepatitis  
caused by unknown  
Due to Operation showed no  
malignancy in Stomach  
4-26-41

Other conditions (Include pregnancy within 3 months of death)

Major findings: Acute hepatitis with  
Of operations non-furcating gall  
Of autopsy bladder

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 9

23. Signature Earl R. Rice (M. D. or other) MD  
Address Francis Hospital Date signed 5-8-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

JUL 8 1941

**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.....

*Albert G. Hopper*

Licensed Embalmer No.....

*2921*

P.O. Address.....

**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.**