V. S. No. 2
00M—8-43
ev. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. F 23370

Registration District No. FILED JUL 26 1944 18 Primary Registration District No. 1008 Registrar's No. 6344

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:
St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED: 000 17 9 12
(a) State Missouri (b) County
(c) City or town City of St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5083 Maple Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) Y
If yes, name country

3. (a) PRINT FULL NAME Sheley C. Reynolds
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Brooksie Reynolds
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased June (Month) 25th (Day) 1883 (Year)

8. AGE: Years 61 Months 0 Days 19 If less than one day hr. min.

9. Birthplace Guthrie Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Salesman
11. Industry or business Union Electric Co.
FATHER
12. Name J. R. Reynolds
13. Birthplace Guthrie Missouri
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Emma Sheley
15. Birthplace Guthrie Missouri
(City, town, or county) (State or foreign country)
16. (a) Informant Brooksie Reynolds
(b) Address 5083 Maple Ave
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-16-44 (Month) (Day) (Year)
(c) Place: burial or cremation Fulton Missouri
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave
19. (a) JUL 18 1944 (Date received local registrar) J. F. Breuch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14th year 1944 hour 12.55 minute P. M.
21. I hereby certify that I attended the deceased from Apr. 19 1944, to July 14 1944, that I last saw him alive on July 14 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Pericarditis	7 days
Due to Acute otitis media	10 days
Due to Acute upper respiratory infection	14 days
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Acute pericarditis

PHYSICIAN — Underline the cause to 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

23. Signature Edwin P. Meiners (M. D. ~~or other~~)
Address 6651 Enright Ave Date signed 7-15-44

(Licensed Embalmer's Statement on Reverse Side)

6341

6341

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 John Ogonoski

Licensed Embalmer No. 3398

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, fact should be so stated above.