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DM—8-43
v. 5-17-39
P I X37823

#32484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 22 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36327

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9514

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: St. Louis City Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4mos-11 days (Specify whether years, months or days)

In this community 73 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis

(c) City or town St Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2620 St Vincent
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Charles Reynolds

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced widower

6. (b) Name of husband or wife deceased

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept 3 1871
(Month) (Day) (Year)

8. AGE: Years 73 Months 2 Days 5 If less than one day hr. min.

9. Birthplace St Louis (City, town, or county) 0 (State or foreign country)

10. Usual occupation Chauffeur

11. Industry or business self

MOTHER FATHER

12. Name George Reynolds

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

14. Maiden name Elizabeth Leche

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

16. (a) Informant Mrs Charlotte Owen

(b) Address Lund Del New Orleans La

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Joseph A Howard

(b) Address 619 N Grand

19. (a) NOV 9 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8th year 1944 hour 11:50 minute A. M.

21. I hereby certify that I attended the deceased from 7/28/44, 19..., to Nov. 8th, 1944, that I last saw him alive on Nov. 8th, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	
Due to	
Due to	
Other conditions Osteomyelitis of jaw (Include pregnancy within 3 months of death)	

107

Major findings: Of operations Surgery on jaw, Tissue Granulation

Of autopsy not done

PHYSICIAN — Underline the cause on 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?

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

23. Signature E. W. Gebhardt (M. D. or other)

Address 7515 Lafayette Date signed 11/8/44

(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.....

....., 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.