

FILED JUL 30 1945 STANDARD CERTIFICATE OF DEATH

State File No. 25083

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1852

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution St. Louis Training School
(If not in hospital or institution, write street name and location)

(d) Length of stay: In hospital or institution 2 1/2 years
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State St. Louis Mo (b) County St. Louis & Lin

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

(d) Street No. St. Louis Training School
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME BERNICE MARIE REYNOLDS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased: September 16, 1938
(Month) (Day) (Year)

8. AGE: Years 12 Months 10 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo
(City, town, or County) (State or foreign country)

10. Usual occupation NRN

11. Industry or business _____

12. Name Leta Reynolds (deceased)

13. Birthplace Illinois
(City, town, or County) (State or foreign country)

14. Maiden name Wynette Williams Reynolds

15. Birthplace Illinois
(City, town, or County) (State or foreign country)

16. (a) Informant Records of St. L. Tr. School

(b) Address Bellfontaine & Hall Rd.

17. (a) Removal (b) Date thereof: 7-25-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sparta, Illinois

18. (a) Signature of funeral director Albert E. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) 7-25-45 (b) G. S. M. Saranin
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23 year 1945 hour 9 minute 18 P. M.

21. I hereby certify that I attended the deceased from November 18 1942, to July 23 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia hypertoxic Duration 2 days

Due to Epilepsy 75

Other conditions: encephalitis residuals
following scarlet fever

Major findings: _____
Of operations _____
Of autopsy _____

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? _____

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

23. Signature Arthur P. Jones (M. D. or other) _____
Address Bellfontaine & Hall Rd. Date signed 7-24-45

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

MOTHER FATHER

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. Haffa*
Licensed Embalmer No..... *2971*
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.