

S. No. 2  
 M-2-43  
 7. 5-17-39  
 X38697

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

39492

State File No. \_\_\_\_\_

**FILED** DEC 21 1945  
 Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10756

1. PLACE OF DEATH:  
 (a) County \_\_\_\_\_  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Louis Children's Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 21 days  
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Ill (b) County Franklin  
 (c) City or town West Frankfort  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2104 East St Louis  
 (If rural, give location)  
 (e) Citizen of foreign country? NR (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Linda Faith McReynolds  
 3. (b) If veteran, name war Nil 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month 12 day 9  
 year 45 hour 7 minute 40 P.M.  
 21. I hereby certify that I attended the deceased from 11-19, 1945, to 12-9, 1945;

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 alive \_\_\_\_\_ years (Day) (Year)

that I last saw her alive on 12-9, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Aspiration pneumonia

8. AGE: Years Months Days If less than one day  
5 28 hr. min.

Duration  
 Due to \_\_\_\_\_  
 Due to 107  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace West Frankfort Ill (City, town, or county) (State or foreign country)  
 10. Usual occupation Infant

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER  
 11. Industry or business \_\_\_\_\_  
 12. Name Leslie William McReynolds  
 13. Birthplace West Frankfort Ill (City, town, or county) (State or foreign country)  
 14. Maiden name W. Adge Thomson  
 15. Birthplace West Frankfort Ill (City, town, or county) (State or foreign country)  
 16. (a) Informant W. Bernard  
 (b) Address 500 S. Kings Highway  
 17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-10-45 (Month) (Day) (Year)  
 (c) Place: burial or cremation West Frankfort, Ill.  
 18. (a) Signature of funeral director Reedy Funeral Home  
 (b) Address West Frankfort, Illinois  
 19. (a) DEC 10 1945 (Date received local registrar) (b) J. F. Bredesch (Registrar's signature)

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 R. J. Blotter (M. D. or other) \_\_\_\_\_  
 Address Dr. R. Kupfner Date signed \_\_\_\_\_

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

*No Embalmed*

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**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.....

Licensed Embalmer No.....

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.**