

S. No. 2
M-5-43
ev. 5-17-39
I X36871

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17952**
Registrar's No. **1192**

Registration District No. **317** Primary Registration District No. **3069**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Richmond Heights**
(c) Name of hospital or institution: **St. Mary's Hospital**
(d) Length of stay: In hospital or institution **2-weeks**
In this community **2-weeks**
years, months or days

3. (a) PRINT FULL NAME **Joseph J. Reynolds**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **M.** 5. Color or race **W.**
6. (a) Single, widowed, married, divorced **W.**
6. (b) Name of husband or wife **Anna D. Reilly**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **June 18th., 1876**
(Month) (Day) (Year)

8. AGE: Years **69** Months **11** Days **11**
If less than one day _____ hr. _____ min.

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

10. Usual occupation **Retired**

11. Industry or business **Mer. Com. Bank & Trust Co.**

12. Name **Thomas Reynolds**

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

14. Maiden name **Catherine Kernan**

15. Birthplace **Ireland U**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Mary R. Reynolds**
(b) Address **5701 Gates Ave.**

17. (a) **Burial** (b) Date thereof **6-1-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Arthur J. Connelly**
(b) Address **3840 Lindell Blvd**
19. (a) **6-1-46** (b) **E. S. McFarland, Jr.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **000**
(c) City or town **St. Louis**
(d) Street No. **5701 Gates Ave.**
(e) Citizen of foreign country? **No**
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **29th.**
year **1946** hour **11** minute **35 p.** M.

21. I hereby certify that I attended the deceased from **5-17**, 1946, to **5-29**, 1946,
that I last saw him alive on **5-29**, 1946,
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**
Cerebral thrombosis
Due to **83K**

Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy **Emphysema, arteriosclerosis in lungs, tumor in liver, yellow lungs.**

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

Physician **Daniel L. Kellan (M.D. or other)**
Signature **Daniel L. Kellan**
Address **607 N. Grand (3)**
Date signed **7/21/46**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
16831

JUN 28 1946

OCT 29 1946

JUN 24 1946
11-1
Univ. Club Bldg. 221750

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

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.