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DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS  
**FILED JUL 26 1948**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**  
**1003**

State File No. **25979**  
 Registrar's No. **6801**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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

**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. Mary's Infirmary  
(If not in hospital or institution, write street number & location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town Independence  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** MINNIE BELLE REYNOLDS  
 3. (b) If veteran, name war --- 3. (c) Social Security No. ---  
 4. Sex Female 5. Color or race C 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Rev. A. L. Reynolds 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Unavailable 1877  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month July day 18th year 1947 hour \_\_\_\_\_ minute 30 A.M.  
 21. I hereby certify that I attended the deceased from July 18 1947 to July 18 1947;  
 that I last saw her alive on July 18 1947;  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>Abt 70</u>			hr. _____ min. _____

Immediate cause of death  
Diabetes Mellitus  
Diabetes gangrene left foot  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death)  
U1

9. Birthplace Warrensburg Mo.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Housewife  
 11. Industry or business ---  
**MOTHER** { 12. Name Dave Talbert  
 13. Birthplace Unknown Mo.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Ellen Unknown  
 15. Birthplace Unknown Mo.  
(City, town, or county) (State or foreign country)  
 16. (a) Informant Dr. A. Leroy Reynolds  
 (b) Address 243 E. Kirkham, Webster Groves  
 17. (a) Removal (b) Date thereof 7-19-47 Mo  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Kansas City, Mo.  
 18. (a) Signature of funeral director Chas. J. Gates  
 (b) Address 4107 Finney Ave  
 19. (a) JUL 20 1947 (b) J. F. Preder  
(Date received local registrar) (Registrar's signature)

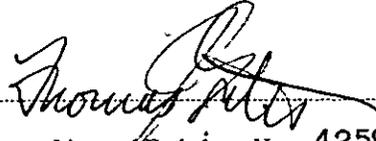
**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 22. If death was due to external cause, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
 (c) \_\_\_\_\_  
 (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 Will Gunge (M. D. or other) \_\_\_\_\_  
 Address St. Mary's Infirmary Date signed 7/18/47

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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.....

..... Thomas J. Gates ....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....  .....

Licensed Embalmer No. 4259 .....

P. O. Address 4107 Finney Ave. .....

**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.**