

FILED JAN 16 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 2940  
190  
Registrar's No.

2559

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) 2109 OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 36 yrs		d. STREET ADDRESS (If rural, give location) 3300 <sup>a</sup> Laclede	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Sallie		b. (Middle) Reynolds	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Jan. 1 50	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 22, 1893
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Days 9 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Miss. 1
12. CITIZEN OF WHAT COUNTRY? U. S. A			
13a. FATHER'S NAME Walter Hickman		13b. MOTHER'S MAIDEN NAME Mary Askell	
14. NAME OF HUSBAND OR WIFE John Reynolds			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Leroy Reynolds		ADDRESS 3300 <sup>a</sup> Laclede	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis ANTECEDENT CAUSES Undetermined Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Tuberculous Osteomyelitis Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY) 12		(STATE) MO	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 20 ft X			
22. I hereby certify that I attended the deceased from 11-12, 1949, to 1-1, 1950, that I last saw the deceased alive on 1-1, 1950, and that death occurred at 1:48a m., from the causes and on the date stated above.			
23a. SIGNATURE James J. Sedbrook		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 1-3-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-7-1950	
24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) St. Louis	
24e. (State) Mo			
DATE REC'D BY LOCAL REG. JAN 5 1950		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR'S SIGNATURE ACKINS BROS		ADDRESS 3644 FINNEY	

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....

Student Embalmer

Signed Louis V. Atkins

Licensed Embalmer No. 2842

P. O. Address 3644 Finley

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.