

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37530

State File No.

FILED OCT 30 1953
BIRTH NO. 56905

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 10186

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

| | | | | | |
|---|-------------------------------|--|---|---|--|
| 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 township) OR TOWN St. Louis, Missouri | | c. LENGTH OF STAY (In this place) | | c. CITY OR TOWN St. Louis, Missouri | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital | | e. STREET ADDRESS 15 2104 Gasconade | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or Print) a. (First) GARY b. (Middle) Wayne c. (Last) REYNOLDS | | | 4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 25, 1953 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never married | 8. DATE OF BIRTH July 29, 1953 | 9. AGE (In years last birthday) 2 | IF UNDER 1 YEAR Months 28 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13a. FATHER'S NAME Kenneth Reynolds | | 13b. MOTHER'S MAIDEN NAME Joan Lovett | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Kenneth Reynolds ADDRESS 2104 Gasconade | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastroenteritis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Prematurity Malnutrition Conditions contributing to the death but not related to the disease or condition causing death. | | | INTERVAL BETWEEN ONSET AND DEATH 5 days |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (STATE) | | |
| 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? 5710 | | |
| 22. I hereby certify that I attended the deceased from 10-22-53 19, to 10-25-53 , 19, that I last saw the deceased alive on 10-25-53 , 19, and that death occurred at 7:50P m., from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE (Degree or title) Elizabeth K. Gay M.D. | | | 23b. ADDRESS 1515 Lafayette Avenue | | 23c. DATE SIGNED 10-26-53 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 10-28-1953 | 24c. NAME OF CEMETERY OR CREMATORY St. Marcus Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis Missouri | | |
| DATE REC'D BY LOCAL REG. OCT 27 1953 | | REGISTRAR'S SIGNATURE Carl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin Funeral Home, Inc. ADDRESS 2301 Lafayette, St. Louis 4, Missouri | |

9335

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.....
Signature of Student Embalmer

Signed *L. R. Cooper*.....

Licensed Embalmer No. *363*

P. O. Address *2307 Lafayette*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.