

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 2 1954

State File No.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 0723

BIRTH NO. _____

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>23 days</u>	c. CITY OR TOWN <u>St. Louis</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>SAINT LOUIS CHRONIC HOSPITAL</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS <u>938 Maryville</u>		(If rural, give location) <u>2059</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARIE</u>	b. (Middle)	c. (Last) <u>REYNOLDS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1 22 1954</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb. 29, 1877</u>	9. AGE (in years last birthday) <u>76</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Daniel Foley</u>	13b. MOTHER'S MAIDEN NAME <u>Catherine McDonald</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas F. Reynolds</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John F. Reynolds</u>	ADDRESS <u>938 Maryville</u>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u>		<u>years</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u>		<u>years</u>
II. OTHER SIGNIFICANT CONDITIONS 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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>4200</u>
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22. I hereby certify that I attended the deceased from Dec. 31, 1953, to Jan. 22, 1954, that I last saw the deceased alive on Jan. 22, 1954, and that death occurred at 2:00P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>George Esker, M.D.</u>	23b. ADDRESS <u>5600 Arsenal St.</u>	23c. DATE SIGNED <u>1/22/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>Jan 25 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis MO</u>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>JAN 23 1954</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Carl Smith</u>	ADDRESS <u>3840 Lindell</u>
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WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

