

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 39481

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 2527

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>CLAYTON</b>		c. CITY OR TOWN <b>Clayton</b> 444 80	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS COUNTY HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>7143 Kingsbury</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>LEROY</b>	b. (Middle) <b>C.</b>	c. (Last) <b>Reynolds.</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 6, 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>AUG. 29, 1900</b>	9. AGE (In years last birthday) <b>54</b>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <b>Supt. Liability Dept. Am. Assoc. Indemnity.</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Philadelphia, Penn.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>William Reynolds.</b>	13b. MOTHER'S MAIDEN NAME <b>Annie Maxwell.</b>	14. NAME OF HUSBAND OR WIFE <b>Ada H. Reynolds.</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>161-03-6247</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Ada H. Reynolds, Clayton, Mo.</b>	ADDRESS
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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 <b>2-3 YRS (?)</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b>		UNKNOWN
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>HYPERTENSION</b> DUE TO (c) <b>ARTERIOSCLEROSIS</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>DUODENAL ULCER</b>		UNKNOWN	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>443X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **MARCH 4, 1952**, to **NOV 5, 1954**, that I last saw the deceased alive on **OCT 26, 1954**, and that death occurred at **3 Am.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Robert S. Warner</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>514 DRIVE ST</b>	23c. DATE SIGNED <b>11/6/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>11/8/1954</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>Smyrna, Delaware</b>
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DATE REC'D BY LOCAL REG. <b>11/6/54</b>	REGISTRAR'S SIGNATURE <b>Heber R. Lamborn</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>C.R. Lupton &amp; Sons</b>	ADDRESS <b>7233 Delmar Blvd</b>
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(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.....  
Signature of Student Embalmer

Signed... *Arnold W. Schoene* .....

Licensed Embalmer No. *3864*

P. O. Address *St. Louis, Mo.*

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.