

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24277

State File No. \_\_\_\_\_  
Registrar's No. **5670**

FILED AUG 2 - 1955

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

<b>I. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis</b> )  d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3846 Maffitt Ave</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b>  d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>  e. STREET ADDRESS (If rural, give location) <b>3846 Maffitt</b>	
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<b>3. NAME OF DECEASED</b> a. (First) <b>BELL</b> b. (Middle) _____ c. (Last) <b>REYNOLDS</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>June 27, 1955</b>			
<b>5. SEX</b> <b>Fem</b>	<b>6. COLOR OR RACE</b> <b>Col</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>May 2, 1902</b>	<b>9. AGE</b> (In years last birthday) <b>53</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Mins. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Okolona, Miss</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> _____

<b>13a. FATHER'S NAME</b> <b>Nathan Hubbard</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mattie Williams</b>	<b>14. NAME OF HUSBAND/OR WIFE</b> <b>LeRoy Reynolds</b>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) _____	<b>16. SOCIAL SECURITY NO.</b> _____	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>LeRoy Reynolds</b> <b>ADDRESS</b> <b>3846 Maffitt Ave</b>

<b>18. CAUSE OF DEATH</b> 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.	<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Hypertensive Cardio-Vascular Disease</b>  <b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		<b>INTERVAL BETWEEN ONSET AND DEATH</b>   _____
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			

<b>19a. DATE OF OPERATION</b> _____	<b>19b. MAJOR FINDINGS OF OPERATION</b> _____	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) _____	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> _____
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____	<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>  <b>443x</b>

22. I hereby certify that I attended the deceased from 6/10, 1955, to 6/27, 1955, that I last saw the deceased alive on 6/27, 1955, and that death occurred at 7:00 PM, from the causes and on the date stated above.

<b>23a. SIGNATURE</b> <i>Clara H. Beene M.D.</i>	<b>23b. ADDRESS</b> <b>205 W. Jefferson Ave.</b>	<b>23c. DATE SIGNED</b> <b>6/29/55</b>
<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>	<b>24b. DATE</b> <b>7/1/55</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Booker T. Washington Cem.</b> <b>24d. LOCATION (City, town, or county) (State)</b> <b>E. St. Louis, Ill</b>

<b>DATE REC'D BY LOCAL REG.</b> <b>JUN 30 1955</b>	<b>REGISTRAR'S SIGNATURE</b> <i>J. Carl Smith M.D.</i>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>R.M. C. Green</b> <b>ADDRESS</b> <b>4060 Washington Ave</b>
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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.....  
*Melvin E. M.*

Licensed Embalmer No. *44*

P. O. Address *J. L.*

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.