Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012205
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2493

1. PLACE OF DEATH
a. COUNTY — —
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) DePaul — Length of stay in 1b 7 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo; b. COUNTY — —
c. CITY OR TOWN St. Louis — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 1427 S. 9th. St. — Reside on Farm Yes ☐ No X

09 23

3. NAME OF DECEASED (Type or print) First: Father Thomas Middle: J. Last: Reynolds C.M.

4. DATE OF DEATH Month: 2 Day: 28 Year: 1958

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ **NEVER MARRIED** X **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH 9/6/1887

9. AGE (In years last birthday) 70

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest

10b. KIND OF BUSINESS OR INDUSTRY Priest

11. BIRTHPLACE (City and state or country) Louisiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME U.K.

14. MOTHER'S MAIDEN NAME U.K.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT Address: Rev. Flynn 1427 S.9th.St. St. Louis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH 7 years

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 7-26-54, to 2-28-58 and last saw her/him alive on 2-28-58
Death occurred at 4 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Md

22b. ADDRESS 3720 Washington

22c. DATE SIGNED 3-1-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 3/3/1958

23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

23d. LOCATION (City, town, or county) St. Louis Mo. (State)

24. FUNERAL DIRECTOR A. Donnelly — **ADDRESS** 3840 Lindell Blvd.

25. DATE RECD. BY LOCAL REG. MAR 1 '58

26. REGISTRAR'S SIGNATURE Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

Form 1035-D
9-12

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed. Wm S Salfen

Licensed Embalmer No. 461

P. O. Address 3840 Lin

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.