

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046210
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12680

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Numer Phillips</u>		d. STREET ADDRESS (If outside, give location) <u>2219 2623 Delmar</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWRENCE J. REYNOLDS</u>		4. DATE OF DEATH Month Day Year <u>12-28-1958</u>	
5. SEX <u>MALE 2</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 22, 1890</u>
9. AGE (In years last birthday) <u>68</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	11. BIRTHPLACE (City and state or country) <u>NASHVILLE TENN. 1</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>
14. NAME OF HUSBAND OR WIFE <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW 1</u>	16. SOCIAL SECURITY NO. <u>489-22-1628</u>
17. INFORMANT Address <u>FLOYD BUSH 2623 Delmar</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis (staphylococcus?)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>340.2</u>	
19. WAS AUTOPSY PERFORMED? 1 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
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 death from _____ and last saw her alive on _____ Death occurred at <u>4:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Patrick Taylor Carver 3</u>		22b. ADDRESS <u>1300 Clark Ave.</u>	
22c. DATE SIGNED <u>12-31-58</u>		23. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. LOCATION (City, town, or county) (State) <u>JEFF. BKS, MO.</u>	
24. FUNERAL DIRECTOR <u>JACKSON FUNERAL HOME 2649 DELMAR</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 30 58</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Smith MO</u> <u>2185</u>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 *Leroy H. Gunnister*

Licensed Embalmer No. *4523*

P. O. Address *4251 Washington*

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.