

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS APR 12 1960

60-013123

2 3379

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN University City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 7075 Corbitt Wve.	

3. NAME OF DECEASED (Type or print) First WILBUR Middle M. Last REYNOLDS	4. DATE OF DEATH Month MARCH Day 23 Year 1960
--	---

5. SEX Male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-22-1907	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
--------------------	-------------------------------	---	-----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) freight driver	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Indiana	12. CITIZEN OF WHAT COUNTRY U. S. A.
--	-----------------------------------	--	--

13a. FATHER'S NAME Reynolds	13b. MOTHER'S MAIDEN NAME Pearl Enlow	14. NAME OF HUSBAND OR WIFE Helen W. Reynolds
---------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Helen W. Reynolds	Address 7075 Corbitt
---	--	--	--------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF RENAL ARTERIES, BILATERAL	INTERVAL BETWEEN ONSET AND DEATH 6 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROSIS	15 YEARS
DUE TO (c) 450.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) DIABETES MELLITUS	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 WORK <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 deceased from **SEPT. 8, 1950** to **MARCH 23, 1960** and last saw her/him alive on **MARCH 23, 1960**
 Death occurred at **5:10 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>E. J. Vermillion, M.D.</i> (Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 3/23/60
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-26-60	23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Missouri
---	-----------------------------	---	--

24. FUNERAL DIRECTOR C.R. Lupton and Sons	ADDRESS 7233 Delmar Blvd.	25. DATE RECD. BY LOCAL REG. MAR 24 1960	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>
---	-------------------------------------	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 19 1966

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clarence A.

Licensed Embalmer No. 4011

P. O. Address St. Paul

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