PLACE OF DEATH

ounty Cooper

Albers

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

wnship

or

llage

or

ty Sedalia (No. ____ St.: ____ Ward)

Registration District No. 668 File No. 30579

Primary Registration District No. 3032 Registered No. 216

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Leo Mray Reid

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	

ATE OF BIRTH Apr 20, 1913 (Month) (Day) (Year)

GE ____ yrs. 5 mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

COUPATION
) Trade, profession, or rticular kind of work —

) General nature of industry, siness, or establishment in ich employed (or employer) —

RTHPLACE
ity or town, Mo
ate or foreign country)

NAME OF FATHER Leo Reid

BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo

MAIDEN NAME OF MOTHER Kiem Daugherty

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

formant) Leo Reid

(ADDRESS) Sedalia Mo

d Sept 14, 1913. A. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept. (Month) 12 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 9, 1913, to Sept 12, 1913, that I last saw him alive on Sept 12, 1913 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

119A

(Duration) ____ yrs. ____ mos. 3 ds.

Contributory (Secondary) None (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Edw A Albers M. D.

Sept 14, 1913 (Address) Sedalia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Smithton Mo — DATE OF BURIAL Sept 15, 1913

UNDERTAKER Sedalia Mo Co — ADDRESS Sedalia Mo

V. S. No. 2.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING

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V. S. No. 2.

PLACE OF DEATH

County_____

Township _____ Registration District No._____ File No._____

or

Village_____ Primary Registration District No._____ Registered No._____

or

City _____ (NO._____, _____ St.; _____ Ward)

[If death occurred in hospital or institution give its NAME instead of street and number]

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, 1_____
(Month) (Day) (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER Conrad Edling

BIRTHPLACE OF FATHER (City or town, State or foreign country) Germany

MAIDEN NAME OF MOTHER Anna Burger

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)_____

(ADDRESS)_____

Filed _____, 191_____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191_____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased fr

_____, 191_____, to _____, 191_____

that I last saw h_____ alive on _____, 191_____

and that death occurred, on the date stated above, at_____

The CAUSE OF DEATH* was as follows:

_____ (Duration) _____ yrs. _____ mos.

Contributory_____
(Secondary)

_____ (Duration) _____ yrs. _____ mos.

(Signed)_____ M.

_____, 191_____ (Address)_____

*State the Disease Causing Death, or, in deaths from Violent Causes, st (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos.

Where was disease contracted if not at place of death? _____

Former or usual residence_____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191
UNDERTAKER	ADDRESS