

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

Do not use this space.

22836

1. PLACE OF DEATH

County Clay Registration District No. 198 File No. _____
Township W. 2nd Primary Registration District No. 3. 0. 1 Registered No. 81
City Excelsior Springs, Mo. (No. East Broadway St. _____ Ward _____)

2. FULL NAME

James Lesley Reed
(a) Residence No. 402 E. Swartz St. 1 Ward Texhoma Okla
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 8 mos. 8 ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 17-1885

7. AGE YEARS 69 MONTHS 5 DAYS 8 IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant.
(b) General nature of industry, business, or establishment in which employed (or employer) Grocery.
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Warrensburg
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER David W. Reed

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Levan
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Mary Lee

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Texhoma
(STATE OR COUNTRY) _____

14. INFORMANT James L. Reed

(Address) Texhoma Okla

15. FILED 8-31, 1924 J. D. Cornew REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19 24

17. I HEREBY CERTIFY, That I attended deceased from 7-19, 1924, to 8-20, 1924 that I last saw him alive on 8-20, 1924, and that death occurred, on the date stated above, at 8-20/00 m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dropsy

131

dnt kno

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED his home

IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH. no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. P. Bailey, M. D.
, 19 (Address) Excelsior Springs Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Warrensburg

DATE OF BURIAL not kno

20. UNDERTAKER Herbert Hope

ADDRESS Excelsior

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

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasma); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

TAKE TO
MARIETTA DRUG STORE
201 So. MARIETTA
PHONE 350

CRAVEN, M. D.
PHONE 491
OFFICE 209 SPRING ST.
EXCELSIOR SPRINGS, Mo.

For

Date

R

This Physician
is ^{not} not a graduate
from any school, and
does not know a
symptom from a disease.

Local Registrar
198.

M. D.
U. S. Reg. No. 3738

1950

37

21

092222

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

Aug 1924

1. PLACE OF DEATH

County Clay Registration District No. 198 File No. _____
 Township _____ Primary Registration District No. 3011 Registered No. 81
 City Ex Springs (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>W</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS	MONTHS
		DAYS
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) STATE OR COUNTRY		
10. NAME OF FATHER		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)		
12. MAIDEN NAME OF MOTHER		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20 1924

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis

CONTRIBUTORY (SECONDARY)
12/9

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
 _____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

14. INFORMANT (Address)	19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
15. FILED <u>10-27-24</u> <u>J. W. Craven</u> REGISTRAR	20. UNDERTAKER	19____ ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

WRITE PLAINLY, WITH INK---THIS IS A PERMANENT RECORD

K. B.—Every item of information should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND CAUSE OF DEATH in plain terms, as far as possible. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL OFFICIATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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