

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

Do not use this space.

20168

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis Mo.** (No. **1618 Pine**) St. _____ Ward _____

File No.....
 Registered No. **5942**
 St. _____ Ward _____

2. FULL NAME

Ora Reed
 (a) Residence. No. **1618 Pine** St. **25** 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Negro** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **June 24th 1892**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **35 0 1**
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work **Laundress**
 (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) **Memphis Tenn**

10. NAME OF FATHER **Solomon Reed**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Tenn. 24**

12. MAIDEN NAME OF MOTHER **Cornelia Manning**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Tenn.**

14. INFORMANT **Jane Scott**
 (Address) **204 So. 16th St.**

15. FILED **28 1927** **Man G Starneoff**
 19 _____ REGISTRY

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 25 1927**
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at **2:50 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremic
93rd Meigs St. (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) **WMA** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **Yes** DATE _____
 WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFERMED DIAGNOSIS?
 (Signed) **[Signature]** M. D.
 _____, 19____ (Address) **Corcoran**

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Greenwood Cemetery** DATE OF BURIAL **June 29 1927**

20. UNDERTAKER **A. L. Beal** ADDRESS **2226 Lucas Ave.**

M. 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.

