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

Do not use this space.

25730

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City St. Louis (No. 5351 Delmar St. ..... Ward)

File No. .....

Registered No. 17328

2. FULL NAME Joseph Cly Reardin

(a) Residence. No. 5351 Delmar St., 12 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 4 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14, 1850

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
77	6	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Unknown

(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) Ky

PARENTS

10. NAME OF FATHER Do not Know

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) "

14. INFORMANT J. T. Short
(Address) 5351 Delmar

15. FILED AUG 11 1927 Mau B Stark Coff
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 14 1927

17. I HEREBY CERTIFY, That I attended deceased from June 22, 1927, to Aug. 14, 1927, that I last saw him alive on Aug. 13, 1927, and that death occurred, on the date stated above, at 7:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemiplegia

Sp. A

Sp. B

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Cerebral Hemorrhage

Apoplexy (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

8/14, 1927 (Signed) D. J. Ry, M. D
(Address) Lester Bldg

*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 Coffeeville Kans — DATE OF BURIAL Aug 14 1927

20. UNDERTAKER Alexander & Sons — ADDRESS 6175 Delmar

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.

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