

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

Do not use this space.

27273

1. PLACE OF DEATH

County Jackson
Township Howe
City Kansas City

Registration District No. 309
Primary Registration District No. 1002

File No. _____
Registered No. 3533
St. _____ Ward)

2. FULL NAME

Nancy E Reed
(a) Residence. No. 2109 College St., _____

(Usual place of abode) _____ (If nonresident give city or town and State)
Length of residence in city or town where death occurred 12 yrs. _____ mos. 11 da. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe | 4. COLOR OR RACE Wh | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 24 1856

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, _____ hrs. or _____ min.
71 | 7 | 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home
(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

10. NAME OF FATHER Martin Bailey

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

12. MAIDEN NAME OF MOTHER Mrs Teyers

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

14. INFORMANT J. M. Reed (Address) 2109 College

15. FILED 974 27 1927 M. H. Crave REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/13 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1927 to Sept 13 1927 (that I last saw her alive on Sept 12 1927, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Indigestion
97
1180

CONTRIBUTORY (SECONDARY) Atherosclerosis
Wittman

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH...
 DID AN OPERATION PRECEDE DEATH W DATE OF _____

WAS THERE AN AUTOPSY? W

WHAT TEST CONFIRMED DIAGNOSIS?
9/13 (Signed) M. D. H. C. M. D. H. C. M. D. H. C.
1/13, 1927 (address) 4325 1/2 Draper St

*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 Forest Hill DATE OF BURIAL Sept. 19 27

20. UNDERTAKER Wm. C. L. Lanter ADDRESS R. C. MO...

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.

405-5

10/10/50

10/10/50

10/10/50

carefully prepared. All other...
state

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Township.....
City *Kansas City* (No.....)

Registration District No. *399*
Primary Registration District No. *1002*

File No.....
Registered No. *3533 -*
St. Ward)

2. FULL NAME

(a) Residence. No..... St., Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *W*

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

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

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

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)

14.

INFORMANT (Address)

15.

FILED *9/14 27* *m. m. Brown* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 13 19 27*

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH WAS AS FOLLOWS:

acute indigestion
State of Unknown (duration)..... yrs..... mos..... ds.
arterio-sclerosis (SECONDARY) (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?

(Signed) *H. S. Senger*, M. D. , 19 (Address) *4525 Prospect Ave*

*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

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be care. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-27273