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

Do not use this space.

28941

1. PLACE OF DEATH

County ..... Registration District No. 791

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

City St Louis (No. 3030 Pine St. ..... Ward)

File No. 8516

Registered No. .....

2. FULL NAME Marie Reed

(a) Residence. No. 3030 Pine St., 21 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) 3-23-1927

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	6	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(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): St Louis Mo

PARENTS

10. NAME OF FATHER: William Reed

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): St Louis Mo

12. MAIDEN NAME OF MOTHER: Mauricia Watson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): St Louis Mo

14. INFORMANT: William Reed
(Address) 3030 Pine St

15. FILED SEP 21 1927, 19..... Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 24, 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1927, to Sept 24, 1927, that I last saw her alive on Sept 22, 1927, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

13c Dysentery

..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (SECONDARY) 16c

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? Home

DID AN OPERATION PRECEDE DEATH? no DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? no

(Signed) J. W. McClellan, M. D

9/24, 1927 (Address) 2344 Pine

*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

DATE OF BURIAL: 9/23 1927

20. UNDERTAKER: A Russell & Co

ADDRESS: 2732 Pine

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