

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

Do not use this space.

32219

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis Mo. (No. Sanitarium) St. .... Ward)

File No.....  
 Registered No. 9627

**2. FULL NAME**

(a) Residence. No. 1280 Hamilton St. Ward. 13  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 35 yrs. + mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
Ruth A Reid

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 3, 1842

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .... hrs. or .... min.
	<u>85</u>	<u>5</u>	<u>25</u>	

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Retired Merchant  
 (b) General nature of industry, business, or establishment in which employed (or employer) Unknown  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY) Missouri

10. NAME OF FATHER James A Reid

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

12. MAIDEN NAME OF MOTHER Mary Wainwright

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

14. INFORMANT William T Gutter, MD  
 (Address) 5300 Arsenal St.

15. FILED OCT 27 1927 May 6 Starck  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/27 19 27

17. I HEREBY CERTIFY, That I attended deceased from Oct 26, 1927, to Oct 27, 1927, that I last saw him alive on Oct 27, 1927, and that death occurred, on the date stated above, at 5:40 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral hemorrhage, apoplexy  
82A

(duration) - yrs. - mos. 2 ds.

CONTRIBUTORY (SECONDARY)  
17401  
 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH. No DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS. Clinical & Lab.  
 (Signed) William T Gutter, M.D.  
10/27, 1927 (Address) 5300 Arsenal 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 <u>burial</u>	DATE OF BURIAL <u>10-28 1927</u>
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20. UNDERTAKER <u>Arthur J Donnelly</u>	ADDRESS <u>2039 Wash St</u>
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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.

RECORD WITH OBTAINING INK—THIS IS A PERMANENT RECORD

