

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

Do not use this space.

35211

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *2112 Oregon*)

File No.

Registered No. **10387**

St. Ward)

2. FULL NAME

(a) Residence. No. *2112 Oregon Ave. St.* *23* 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 *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF *Edward C Reid*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 13 - 1864*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *63 0 5*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *St. Louis* (STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *Secker*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Edward Reid* (Address) *2112 Oregon Ave.*

15. FILED *34 20 1927* *Ma. C. Starkeoff* REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 18 1927*

17. I HEREBY CERTIFY, That I attended deceased from *10:10* *1927*, to *Nov 19 1927*, that I last saw him alive on *Nov 16 1927*, and that death occurred, on the date stated above, at *10:10 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

92R
Essential Insufficiency
Embolism of Coronary artery
(duration)..... yrs. mos. ds.

CONTRIBUTORY *Chr. Myocarditis* (SECONDARY) (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *POA*

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *B. Lew* M. D.

11/19, 1927 (Address) *1807 S 88th 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 *St. Matthews* DATE OF BURIAL *Nov 21 1927*

20. UNDERTAKER *Wacker-Heldorfc* ADDRESS *2331 S. Blum*

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.

