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

Do not use this space.

38911

File No. .....

Registered No. 11651

1. PLACE OF DEATH

County .....

Township .....

City St. Louis (No. City Hospital #2 St. ..... Ward)

Registration District No. 791

Primary Registration District No. 1003

2. FULL NAME Oliver Reed

(a) Residence. No. 3708 Lucas St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ..... mos. ..... 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	Col.	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 13, 1898

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	29	9	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) Mo.

PARENTS

10. NAME OF FATHER George Reed

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Anna F. Woodard
(Address) City Hospital #2

15. FILED ..... 28, 1927 Mark Starsof REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 25, 1927

17. I HEREBY CERTIFY, That I attended deceased from 12/24, 1927, to 12/25, 1927 that I last saw h. alive on 12/25, 1927, and that death occurred, on the date stated above, at 12:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
93C
107A
Acute (duration) ..... yrs. ..... mos. 0 ds.

CONTRIBUTORY (SECONDARY) Myocarditis
Chronic (duration) ..... yrs. 2 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED ..... IF NOT AT PLACE OF DEATH? not known

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) L. L. Gerlly M. D.

, 19 (Address) City Hosp. #2

*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 Kirkwood Memorial

DATE OF BURIAL [illegible] 1928

20. UNDERTAKER Elmer E. Letter

ADDRESS 3030 Bell

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.