

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

Do not use this space.

7856

1. PLACE OF DEATH

County Buchanan

Registration District No. 85

File No. _____

Township _____

Primary Registration District No. 1001

Registered No. 296

City St. Joseph Mo. (No. 1001)

Hoyes Hospital

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Colonial Hotel St. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

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)

Unknown 1883

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

45 Unknown

8. OCCUPATION OF DECEASED

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

Cook

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

✓

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

De Kalb County

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Abe Reynolds

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

Kentucky

12. MAIDEN NAME OF MOTHER

Addie Reed

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

Illinois

14. INFORMANT

(Name and address)

Robert S. Reed

816 1/2 Francis

15. FILED

MAILED 8

1928

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 8 1928

17.

I HEREBY CERTIFY, That I attended deceased from March 1st, 1928, to March 6, 1928 that I last saw h.i./a. alive on March 6, 1928, and that death occurred, on the date stated above, at 11:45 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Valvular Heart Lesion

92A/10W (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) Mitral Insufficiency

(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

3/8 (Signed) J. H. Stanger, M. D. (Address) St. Joseph Mo.

*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

Ashland Cemetery

March 8 1928

20. UNDERTAKER

ADDRESS

Fleman Funeral Home 1208 Francis

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.

