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

Do not use this space.

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1. PLACE OF DEATH
County: Boone
Township: Central
City: Columbia (No. ..... St. ..... Ward)
Registration District No. 73
Primary Registration District No. 3006
File No. .....
Registered No. .....

2. FULL NAME: Betty Jean Reed
(a) Residence. No. Jackson Rd + 40 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. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Baby

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Baby

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 8th 1929

7. AGE: — YEARS: — MONTHS: — DAYS: 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: (0)

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Columbia

PARENTS
10. NAME OF FATHER: Joseph Willard Reed
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Randolph Co
12. MAIDEN NAME OF MOTHER: Ethel Leroy Reed
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Saline Co

14. INFORMANT: J W Reed
(Address): Columbia

15. FILED 1/19 1929 Beatrice Grubb REGISTRAR
LCS

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 1 - 19 - 1929

17. I HEREBY CERTIFY, That I attended deceased from 1 - 8 - 1929, to 1 - 19 - 1929, that I last saw her alive on 1 - 18 - 1929, and that death occurred, on the date stated above, at 2 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature Birth 3 lbs.
159 / 61 A
(duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (SECONDARY): Mother had Flu
(duration) ..... yrs. ..... mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) W. P. Dysart, M. D.
, 19 (Address) Columbia, 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: Huntsville Cem Randolph Co
DATE OF BURIAL: Jan 20 1929

20. UNDERTAKER: R O Willett
ADDRESS: Columbia

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.

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