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

Do not use this space.

10409

PR 24 1929

1. PLACE OF DEATH
County Henry
Township Bethlehem
City ..... (No. ....., ... St. ..... Ward)

Registration District No. 347
Primary Registration District No. 5489A
File No. .....
Registered No. 54

2. FULL NAME James Alexander Reid
(a) Residence No. ..... 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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 5 1851

7. AGE: 77 YEARS, 7 MONTHS, 24 DAYS. If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Henry Co-Mo

PARENTS
10. NAME OF FATHER: Alfred Reid
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know
12. MAIDEN NAME OF MOTHER: Nancy Lee Reid
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Henry Co-Mo

14. INFORMANT: W W Reid
(Address): Clinton Mo

15. FILED Mar. 30, 1929 Dr E C Peelor REGISTRAR per J.G.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 3-29 1929

17. I HEREBY CERTIFY, That I attended deceased from Mch 28, 1929, to Mch 29, 1929, that I last saw him alive on Mch 29, 1929, and that death occurred, on the date stated above, at 9 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ulcer of stomach
11 7 18
..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY): 11 18 18
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) G L Walker, M. D
3:30, 1929 (Address) Clinton 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: Clinton Mo
DATE OF BURIAL: Mar 31 1929

20. UNDERTAKER: Spore & Son
ADDRESS: Clinton Mo

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.