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

Do not use this space.

12679

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1002 Registered No. 3213

City St. Louis (No. 4402 A Maffitt St. ..... Ward)

2. FULL NAME Washington Reed

(a) Residence. No. 4402 Maffitt St., 11 Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): abt 1864

7. AGE: abt 65 yrs. Years Month [illegible] Days Unknown. If LESS than 1 day, ... hrs. or ..... min.

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): Louisville Ky

PARENTS

10. NAME OF FATHER: Washington Reed
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ky
12. MAIDEN NAME OF MOTHER: Clarissa Smith
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ky

14. INFORMANT (Address): Mrs Maggie Reed 4402 Maffitt Av

15. FILED ....., 19.. [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 10 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 26, 1929, to Mar 10, 1929 that I last saw him alive on Mar 10, 1929 and that death occurred, on the date stated above, at 11:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
107 A
163 (duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (SECONDARY): Senility
(duration) — yrs. — mos. — ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) J D Thurman M.D.

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*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: Greenwood Cem

DATE OF BURIAL: Mar 16 1929

20. UNDERTAKER: W.C. Gordon Und. Co.

ADDRESS: 2649 Morgan St.

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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