

1929

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

Do not use this space.

15459

1. PLACE OF DEATH

County New MadridRegistration District No. 82Township EastPrimary Registration District No. 6070City New Madrid (No. 5801)File No. 30

Registered No. _____

St. _____ Ward _____

2. FULL NAME Basil N. 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Rochel Reid6. DATE OF BIRTH (MONTH, DAY AND YEAR) aug 6 - 19587. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 8 18 —

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) _____
 (c) Name of employer _____9. BIRTHPLACE (CITY OR TOWN) New Madrid, G.
 (STATE OR COUNTRY) mo10. NAME OF FATHER Batiste Reid11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Germany12. MAIDEN NAME OF MOTHER Mary Ann Crow13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky.
 (STATE OR COUNTRY) _____14. INFORMANT Evelyn Reid
 (Address) New Madrid, Co.15. FILED 5/10/29 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/20 192917. I HEREBY CERTIFY, That I attended deceased from 4/23/29, 19____, to 4/24/29, 19____, that I last saw him alive on 4/24/29, 19____, and that death occurred, on the date stated above, at 6:30 A. m.THE CAUSE OF DEATH* WAS AS FOLLOWS: (accident)fracture 4-5-6-7 ribs left side. Rupture left lung. Subcutaneous emphysema. Fracture skull. Star left HemeraCONTRIBUTORY Hemorrhox (SECONDARY) (duration) yrs. mos. ds. also

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____WAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? Physical Examination(Signed) Howard M. Reid, M. D., 19____ (Address) Sebaston Mo.

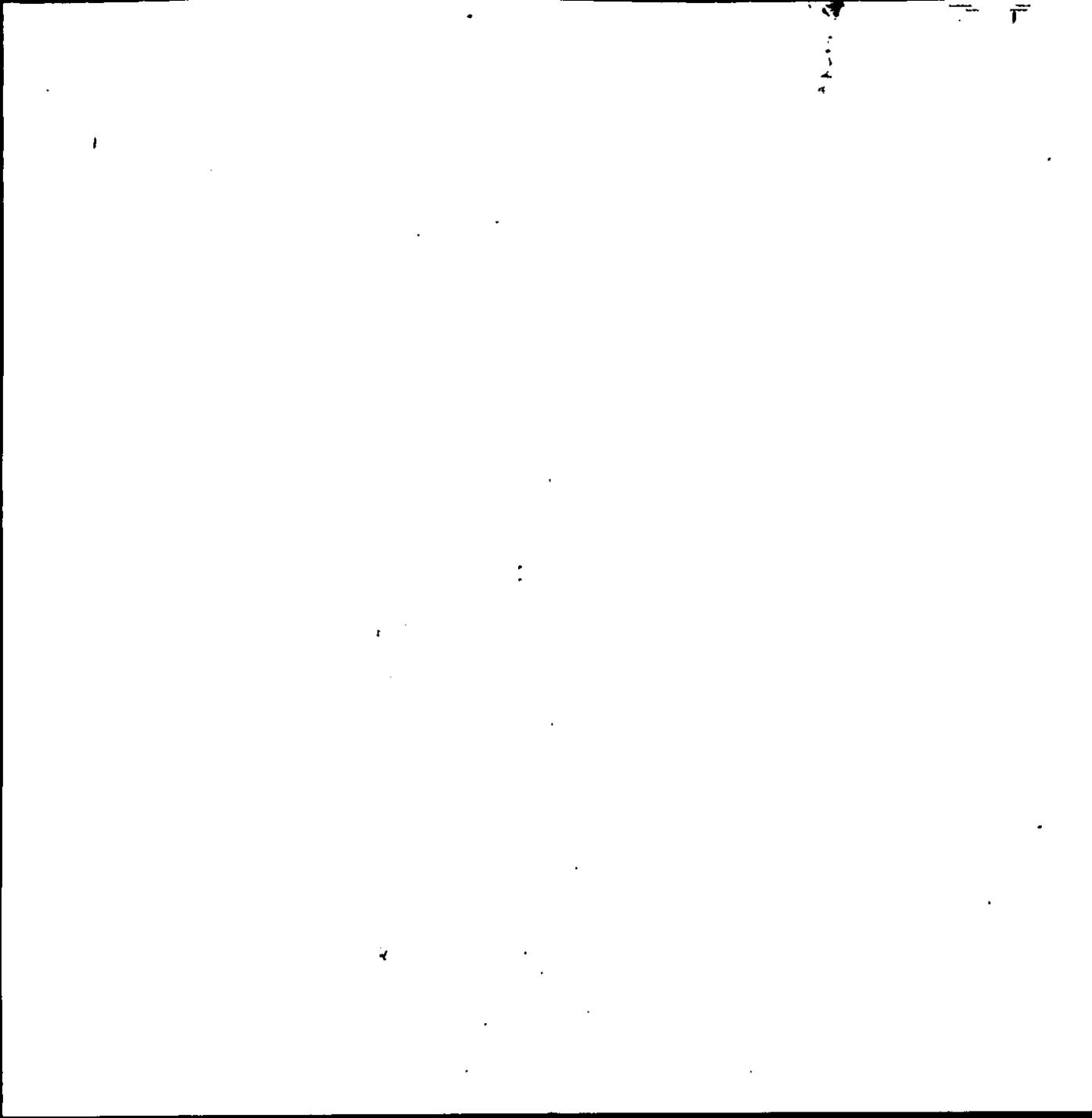
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Coe Green Cemetery April 27 1929

20. UNDERTAKER ADDRESS

Richard's Und Co., New Madrid, Mo.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County New Madrid Registration District No. 821 File No. _____
Township East Primary Registration District No. 5801 Registered No. 30
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Rail N. Raidt
(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 <u>M</u>	4. COLOR OR RACE- <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>/</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, _____ hr. 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 _____		

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) _____

PARENTS	10. NAME OF FATHER _____
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
	12. MAIDEN NAME OF MOTHER _____
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____
(Address) _____

15. FILED 3/10/29 Wata E. Lewis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/24 1929

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accident - Fracture 4-5-6-7 ribs left side. Rupture of left lung.
(duration) yrs. mos. ds. _____
CONTRIBUTORY (SECONDARY) Automobile Accident
New Madrid Mo.
(duration) yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTRACTED New Madrid Co.

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) 1880 _____ M. D.
, 19____ (Address) _____

*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 _____ 19____
20. UNDERTAKER _____	ADDRESS _____

SUPPLEMENTARY

1929

#15459