

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

Do not use this space.

18215

**1. PLACE OF DEATH**

County Jackson  
Township New  
City Kansas City (No. Kansas City Gene Hosp)

Registration District No. 1002

Primary Registration District No. \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. 2260 (Ward) \_\_\_\_\_

**2. FULL NAME** Reed David B.

(a) Residence. No. 6712 Monree St., 16 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 24 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) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jessie Divorced

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-14-1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
6 : 3 : 0

**8. OCCUPATION OF DECEASED**

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

10. NAME OF FATHER Wm Reed

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Pekin

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Reena Clark

(Address) K.C. Gene Hosp

15. FILED 5/16/29 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-14 1929

17. I HEREBY CERTIFY, That I attended deceased from 5-13 1929 to 5-14 1929 that I last saw him alive on 5-14 1929 and that death occurred, on the date stated above, at 5:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

myocardial insufficiency

9:30 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (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? no

WHAT TEST CONFIRMED DIAGNOSIS Chem & endosp  
(Signed) P. E. Lehmann, M. D.

5-14 1929 (Address) Supt KC Gene Hosp

\*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**

Wm Washington

**DATE OF BURIAL**

5-17-29

**20. UNDERTAKER**

O. V. Mart

**ADDRESS**

K.C. Mo

CAUSE OF DEATH in plain language may be written on this space if it may be helpful.



**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..... Registration District No. 399 File No. ....  
Township..... Primary Registration District No. 1002 Registered No. 2260  
City K. City (No. ....) St. .... Ward)

**2. FULL NAME**

David B. Reed

(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) Div.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14 - 1864

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
65 3 1

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) .... yrs. .... mos. .... ds.  
(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)

**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 2/16, 19 29 Jn. M. Cronin REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-14 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:**

CONTRIBUTORY (SECONDARY)

**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)..... 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

20. UNDERTAKER ADDRESS

Information should be supplied. AGE should be stated. EXACTLY. PHYSICIANS should state N. B. Every item of information should be carefully checked. Exact at the time of death. CAUSE OF DEATH in plain words, so that it may be readily understood. OCCASION OF DEATH is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-18215