

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

Do not use this space. 21639

1. PLACE OF DEATH  
 County Jackson Registration District No. 199  
 Township Raw Primary Registrar District No. 1002  
 City Kansas City (No. 1519 Troost) St. 2 Ward 2  
 File No. 2779  
 Registered No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Ernest Reed  
 (a) Residence, No. 1519 Troost St. 2 Ward 2  
 (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 Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unk. 1875

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
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8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Comm. 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) Missouri

10. NAME OF FATHER Chas Reed

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

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT Ollie Reed  
 (Address) 1519 Troost.

15. FILED 6/24/29 M. M. Crow  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/21 1929

17. I HEREBY CERTIFY, That I attended deceased from 6-18-29 to 6-21-29 1929  
 that I last saw him alive on 6-20 1929 and that death occurred, on the date stated above, at 1:15 p. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

uremia  
131  
1328  
Acute (duration) yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) Chronic Interstitial Nephritis (duration) Acute yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Acute Known  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? clinical  
 (Signed) J. F. Scott M. D.  
4/1 1929 (Address) 1702 E. 12th St. Kansas City

\*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 Highland Cem. DATE OF BURIAL 6/24/29

20. UNDERTAKER Natkins Brothers ADDRESS 1729 Lyda

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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Dr. G. H. Brown.

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