

23 1929 James

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

Do not use this space.

24227

1. PLACE OF DEATH

County Douglas Co Registration District No. 276
Township Wood Primary Registration District No. 5389
City Mountain Grove

File No. _____
Registered No. 7
St. _____ Ward _____

2. FULL NAME

Bois Max Gene Reed

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1/1/27

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
- 1 21

8. OCCUPATION OF DECEASED Child
(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) Douglas Co
(STATE OR COUNTRY) Wood Township

10. NAME OF FATHER T. C. Reed

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Douglas Co Wood Township
(STATE OR COUNTRY) Mo Route 6

12. MAIDEN NAME OF MOTHER Richardson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Clinton Township
(STATE OR COUNTRY) Mo Route 7

14. INFORMANT T. C. Reed
(Address) Mountain Grove, Mo

15. FILED July 25 1929 E. C. Sullivan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 22 - 1929

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 22, 1929 that I last saw h. alive on July 22, 1929, and that death occurred, on the date stated above, at 4 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature birth
Less than 7 months 151
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 161 W
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Place of birth
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. G. James, M. D.
. 19 (Address) Intn Grove 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 Pleasant Hill DATE OF BURIAL July 23 1929

20. UNDERTAKER no ADDRESS _____

1870

**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 Doniphan Registration District No. 276 File No. _____
 Township Wood Primary Registration District No. 1-389 Registered No. _____
 City _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME

Jois May Jeane 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 11 29
~~July 8 29~~

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
21

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) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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 July 20 19 29 Ethel Sutherland REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 22 19 29

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) _____ (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) _____, 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 _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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