

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

Do not use this space.

25870

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City..... (No..... St..... Ward.....)

File No. 7048
Registered No. 7048

2. FULL NAME

William Reed
(a) Residence. No. 303 Hickory St., 17 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 col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1 - 1898

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
36 2 -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Lumber
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER Henderson Reed

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

12. MAIDEN NAME OF MOTHER Norcisa Stiff

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

14. INFORMANT Robert Reed

(Address) 303 Hickory St

15. FILED 1 19 29 May C. Stiff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-1-1929

17. I HEREBY CERTIFY, That I attended deceased from 6-2-1929 to 7-1-1929, and that death occurred, on the date stated above, at 6:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia T.B.
Tuberculosis
138

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) Pneumonia T.B.

(duration) yrs. 1 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

Unknown

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) H. C. Vincent, M. D.

, 19 (Address) 239 So. Jefferson

*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

Centerville Miss 7-5-1929

20. UNDERTAKER ADDRESS

Watson and Son 2941 Choate

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.

1928

WRITE IN PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

APR 19 1945