6 1929

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

Do not use this space.

31715

1. PLACE OF DEATH

County: St. Clair — Registration District No.: 766 — File No.:

Township: Roscoe Mo — Primary Registration District No.: 6011 — Registered No.:

City: (No. ..... St. ..... Ward)

2. FULL NAME: George Washington Reed

(a) Residence. No. ..... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 11 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: Nancy Jane Reed

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
76	3	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Merchant

(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

PARENTS

10. NAME OF FATHER: Alexander Reed

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

12. MAIDEN NAME OF MOTHER: Lina Buck

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

14. INFORMANT: J. S. Reed
(Address): Oyer Mo

15. FILED 9/16 1929 J. P. Green REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept. 16 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1929, to Sept. 16, 1929, that I last saw him alive on Sept. 15, 1929, and that death occurred, on the date stated above, at 6-15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis

22A

(duration) 25 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? General Symptoms

(Signed) J. P. Green, M. D

9/16, 1929 (Address) Roscoe 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: Oyer Cemetery — DATE OF BURIAL: 9/17 1929

20. UNDERTAKER: F. B. Goodrich — ADDRESS: Roscoe 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: St. Clair Registration District No.: 766 File No.:
Township: Roscoe Primary Registration District No.: 6011 Registered No.:
City: (No. , St. Ward)

2. FULL NAME: George Washington Reed
(a) Residence. No. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 10 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	3	6	

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 10/2, 1929 J. P. Green REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 16 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:
Tuberculosis
Lung
(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?
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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY 31

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

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