

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

Do not use this space.

38062

1. PLACE OF DEATH

County Pike Registration District No. 685
 Township Calemet Primary Registration District No. 5907 B
 City Anada (No.) St. Ward

File No. 20
 Registered No. 31

2. FULL NAME Wilmer Handy 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 Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nancy Reed		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) AUG. 6 1845		
7. AGE YEARS 84	MONTHS 3	DAYS 15
IF LESS than 1 day, hrs. or min.		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Retired Farmer**
 (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) **Maryland**

PARENTS

10. NAME OF FATHER **Unknown**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**
 12. MAIDEN NAME OF MOTHER **Unknown**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

14. INFORMANT **Eddie H Reed**
 (Address) **Anada Mo**

15. FILED Dec 2, 1929 H. H. Treadway REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **NOV. 21, 1929**

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Nov 21, 1929 that I last saw h. 1 M. alive on Nov 21, 1929, and that death occurred, on the date stated above, at 3:25 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis
 (duration) yrs. mos. 4 ds.
 CONTRIBUTORY **Prostatitis**
 (SECONDARY) (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **132 B**
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH..... DATE OF.....
 WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS **Physical diagnosis**
 (Signed) **Chas H. Overhook** M. D.
11/21, 19 (Address) **Paysonville 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 **Clarksville Mo.** DATE OF BURIAL **11-23-1929**
 20. UNDERTAKER **L. Brown Clarksville** ADDRESS

RECORD WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

8 2

1 2

31

