APR 28 1930

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

Do not use this space.

8366

File No. 213
Registered No.

1. PLACE OF DEATH
County: Greene
Registration District No. 318
Township: Springfield
Primary Registration District No. 2001
City (No. 1343 N. Jefferson St. Ward)

2. FULL NAME: William E. Reed
(a) Residence. No. 1343 N. Jefferson 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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~: Maggie M. Reed

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 11 1878

7. AGE: Years 51. Months 3 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Druggist 101
(b) General nature of industry, business, or establishment in which employed (or employer): 112
(c) Name of employer: W. A. Reed & Son

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.

PARENTS

10. NAME OF FATHER: Wm. A. Reed
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Texas
12. MAIDEN NAME OF MOTHER: Mary Jane Barnett
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo.

14. INFORMANT: John A. Reed
(Address) Springfield, Mo.

15. FILED 3-10-1930 Lon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar 9" 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1930, to ~~[illegible]~~ Mar 9, 1930, that I last saw h~~e~~ alive on Mar. 9, 1930, and that death occurred, on the date stated above, at 10:37 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Asthma
and Bronchial Pneumonia
(duration) yrs. 10 mos. ds.

CONTRIBUTORY (SECONDARY): Bronchial Asthma
(duration) yrs. 1 mos. ds.

18. WHERE WAS DISEASE CONTRACTED? At Home
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) Clifford E. Potter, M. D.
3/10/30 19 (Address) Springfield 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: Maple Park Cemetery
DATE OF BURIAL: Mar 11 1930

20. UNDERTAKER: J. N. Klingner & Co. 424 E. Comm St.
ADDRESS: Springfield, Mo.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD