

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

Do not use this space.

19611

1. PLACE OF DEATH

County Jackson
Township Flaw
City Kansas City (No. 42 1/2 E 15)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 2012
St. 2012 Ward)

2. FULL NAME

(a) Residence. No. 42 1/2 E 15 St., 2 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 17 - 1889

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
41 1 3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Printer H.C.
(b) General nature of industry, business, or establishment in which employed (or employer) typographical union # 80
(c) Name of employer sec J.C. Baker 320 L. L. Bldg

9. BIRTHPLACE (CITY OR TOWN) St Joseph Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Columbus Harrison Reed.

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

12. MAIDEN NAME OF MOTHER Sarah Elizabeth Duesky

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

14. INFORMANT Clay D. Reed
(Address) J. P. Mo.

15. FILED 7/23 30 M. M. Coover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1930

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: found 10 9 decomposed Body

200A (duration) yrs. mos. ds.

CONTRIBUTOR (SECONDARY) 205R (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

19. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS history Inspection
(Signed) Stanley M. Hall, M. D.
(Address) Deputy Coroner

*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 Forest Hill DATE OF BURIAL June 23 1930

20. UNDERTAKER Elyar Funeral Home 1800 Linnwood

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.

Handwritten text in Urdu script, possibly a signature or name, oriented vertically.