

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

Do not use this space.

36969-2
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1. PLACE OF DEATH

County Osceola Registration District No. 655
 Township Virginia Primary Registration District No. 5872
 City Winters (No.) St. Ward)

File No.
 Registered No.

2. FULL NAME William F. Reeves

(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 7 yrs. 0 mos. 0 ds., How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-9-1930

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

17. I HEREBY CERTIFY, That I attended deceased from only Jan 1930 to May 1930, 1930 that last saw h. alive on May 3 1930 and that death occurred, on the date stated above, at 3 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-13-1878

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
57 8 24

T.B.
31 (duration) 1 yrs. 0 mos. 0 ds.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) ---
 (c) Name of employer ---

CONTRIBUTORY (SECONDARY) --- (duration) yrs. mos. ds.

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

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

10. NAME OF FATHER Jewell Reeves

DID AN OPERATION PRECEDE DEATH? --- DATE OF ---

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

19. WAS THERE AN AUTOPSY? ---

12. MAIDEN NAME OF MOTHER Charity Manning

WHAT TEST CONFIRMED DIAGNOSIS Laboratory w.

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

(Signed) J. B. McManis, M. D.

14. INFORMANT Mrs. Minnie Crawford (Address) Stiles 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.

15. FILED 11/10/1930 Max P. Kelly REGISTRAR

PLACE OF BURIAL, CREMATION, OR REMOVAL mt Zionan DATE OF BURIAL 11-10-1930

20. UNDERTAKER German mchcs ADDRESS Stiles Mo

Exact statement of OCCUPATION is very important.

in plain terms, so that it may be properly classified.

1931 JAN 21 1931

100

100

100

100

100

100

100

**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 Demarest
Township Berquima
City (No.) St. Ward)

Registration District No. 655-
Primary Registration District No. 3-872

File No.
Registered No.

2. FULL NAME

William F. Reeves
(a) Residence No. St. Ward.
(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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M

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

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

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)

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)

PARENTS

14. INFORMANT

(Address)

FILED 19

Max P. Kelley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

11/9 1930

17.

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on, 19, and that death occurred, on the date stated above, at

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:

tuberculosis of lungs

CONTRIBUTORY (SECONDARY)

31

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

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

SHALL NOT RECEIVE A FEE
CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
EXACT STATEMENT OF OCCUPATION IN EVERY INSTANCE
AGE SHOULD BE EXACTLY SUGGESTED
DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED.

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