

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

Do not use this space.

4054

**1. PLACE OF DEATH**

23 County Clark Registration District No. 189  
Township Clay Primary Registration District No. 5243  
City (No. ....) St. .... Ward .....

**2. FULL NAME**

Mary Florence 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 Female 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF .....

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 3, 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
56 11 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. " "  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois 2

FATHER 13. NAME Lucian Reed

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER 15. MAIDEN NAME Rhoda Hendricks

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT (ADDRESS) Harve Reed  
Wayland Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Medill Cem. DATE 2/19 1932

19. UNDERTAKER (ADDRESS) Fred. H. Kase  
Wayland Mo.

20. FILED Feb 8 1932 F. O. S. Reed M.D.  
Registrar.

**2 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 7 1932

22. I HEREBY CERTIFY, That I attended deceased from ing 18 1931, to Feb 5 1932  
I last saw him alive on Jan 20 19..... Death is said to have occurred on the date stated above, at 5 A.M.  
The principal cause of death and related causes of importance were as follows:

absence of stomach up  
Strangulated Hernia  
1220  
Other contributory causes of importance:  
1110 1220 A

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? .....  
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify (Signed) F. O. S. Reed M. D.  
(Address) Alexandria Mo

WRITE PLAINLY, 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.

FEB 23 1932

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