

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

Do not use this space.

16639

**1. PLACE OF DEATH**

55 County Lawrence Registration District No. 469  
Township Miller home Primary Registration District No. 4-28  
City Miller (No. 15-632) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. L  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Poie Oma Reed  
(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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 17 1932

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

17. I HEREBY CERTIFY, That I attended deceased from Apr 18 1932 to May 17 1932 that I last saw her... alive on May 16 1932 and that death occurred, on the date stated above, at 4:30 a. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 23-1907

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Salpingitis with abscess  
of perforated  
uterus.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 24 5 23

CONTRIBUTORY (SECONDARY) Intestinal Influenza  
(duration) yrs. mos. 29 ds. (duration) yrs. mos. 10 ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. (D)

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) near Miller mo

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

10. NAME OF FATHER J. L. Sexton

WAS THERE AN AUTOPSY? no

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) unknown mo

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) L. J. Holme M. D.

12. MAIDEN NAME OF MOTHER Bessie Boverman

, 19 (Address) Miller. mo

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

14. INFORMANT (Address) Mrs J. L. Sexton Miller mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL Rennohara Co May 18 1932

15. FILED 6-1 1932 U.S. Bureau REGISTRAR

20. UNDERTAKER Harrison Undertaking ADDRESS Greenfield mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUN 23 1932



**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 Lawrence Registration District No. 469  
Township Greene Primary Registration District No. 5-632  
City..... (No....., St....., Ward.....)

File No.....  
Registered No. 6  
St..... Ward.....

**2. FULL NAME**

Toie Emma 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 23 - 1907

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE.....19.....

19. UNDERTAKER (ADDRESS)

20. FILED 6-1 19 32 W. B. Burrey Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 17, 1932

22. I HEREBY CERTIFY, That I attended deceased from....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Sepsis with tubercular perforation rupture of peritoneum  
non purulent  
Intestinal Influenza

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)....., M. D.  
(Address).....

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.  
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.

S-16609