

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

Dr. J. E. E.
Do not use this space.
23777

1. PLACE OF DEATH

County *Pemiscot*
Township *Pemiscot*
City *Troy* (No. _____)

Registration District No. *651*
Primary Registration District No. *5568*

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Charles D. Reid

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. *2* mos. *16* ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *m* 4. COLOR OR RACE *w* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Infant*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *3-21-1936*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2 16

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) *Troy Mo*

13. NAME *Frank Reid*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Cooler Mo*

15. MAIDEN NAME *Edith Hendrix*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Cottonwood Mo*

17. INFORMANT (ADDRESS) *Frank Reid
Cooler Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *mt Zion* DATE *6-8-36*

19. UNDERTAKER (ADDRESS) *German Undert Co
Stiles Mo*

20. FILED _____ 19 _____ Registrar _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *6-7-36*

22. I HEREBY CERTIFY, That I attended deceased from *6-4-36*, to *6-7-36*

I last saw him alive on *6-7-36* Death is said to have occurred on the date stated above, at *1:00 p.m.*

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

Ulaemia
Date of onset _____
Other contributory causes of importance: _____

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

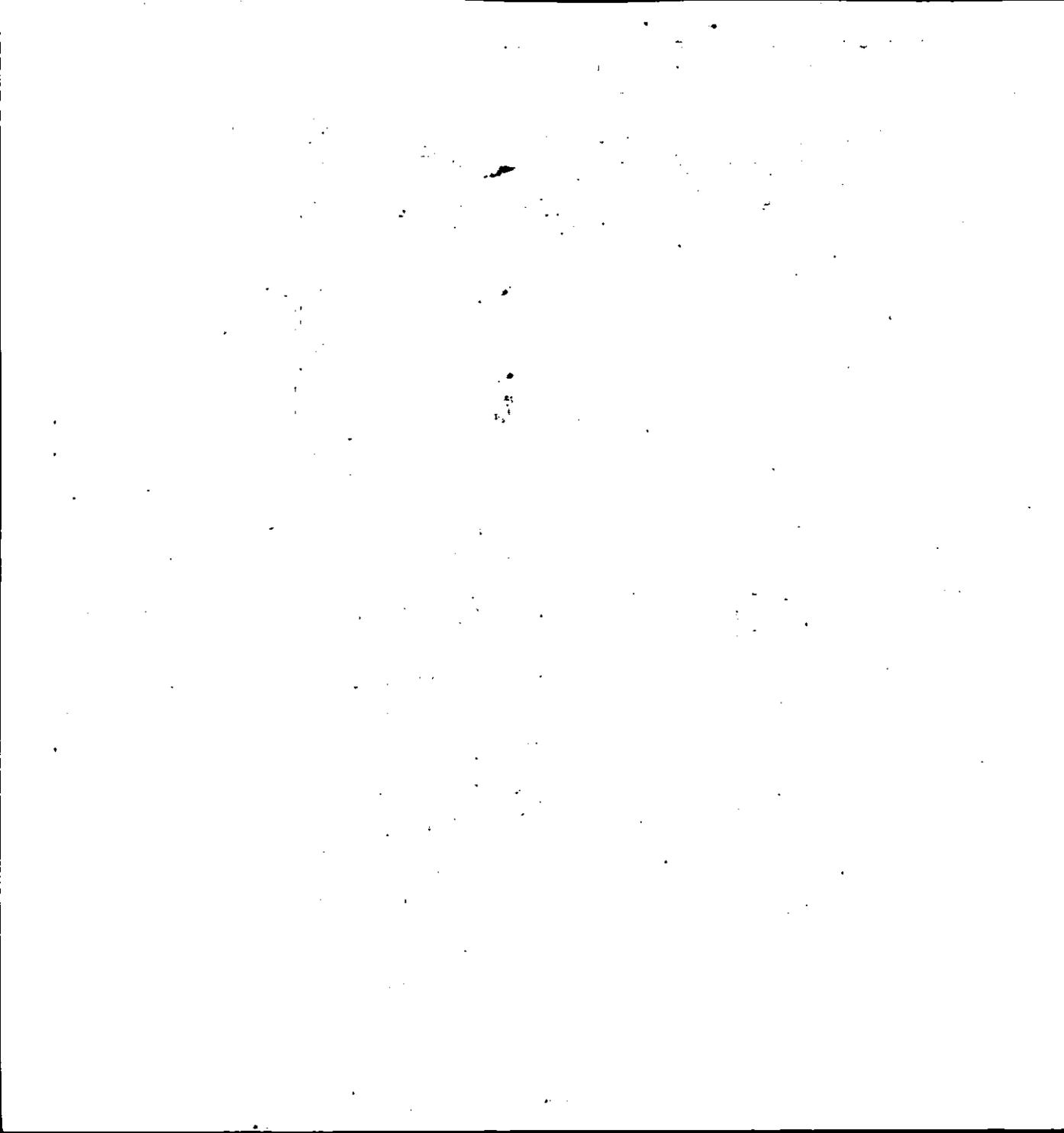
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____

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) *R. E. Cooper*, M. D.
(Address) *Cooler, Mo.*



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1. PLACE OF DEATH

County Pemiscot
Township Pemiscot
City..... (No. St. Ward)

Registration District No. 651
Primary Registration District No. 5863

File No.
Registered No. 109

2. FULL NAME

Charles W. Reid

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) mf

5A. IF 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.
	0	2	16	

OCCUPATION

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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED Sept. 11, 1936 Ada Martin Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-7-36

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

I last saw him 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:

Malnutrition
insufficient food

Other contributory causes of importance

Date of onset

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) H. E. Cooper M. D.
Cooper (Address)

1380

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100
100
100

RECEIVED