

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.

MAY 7 1937

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

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis, Mo.** (No. **Barnard, Skin & Cancer Hospital**) St. Ward)

File No. **14696**
Registered No. **4192**

2. FULL NAME

Robert Reed
(a) Residence, No. **5251 N. Broadway** St. Ward. **9**
(Usual place of abode) ~~non-resident~~ (If nonresident, give city or town and State)
Length of residence in city or town where death occurred ~~.....~~ 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) **married**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **6-26-59**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
37	5	77	9	26

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

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) **St. Charles, Mo.**

13. NAME **Philander Reed**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **N.Y.**

15. MAIDEN NAME **Rebecca Finch**

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

17. INFORMANT **Charlotte Reed**
(ADDRESS) **5251 N. Broadway**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **Corning, Arkansas** DATE **April 24** 19**37**

19. UNDERTAKER **Albert H. Hoppe Inc.**
(ADDRESS) **429 N. Euclid Avenue**

20. FILED **APR 22 1937** **J. F. Bredeck**
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4-22** 19**37**

22. I HEREBY CERTIFY, That I attended deceased from **4-12** 19**37** to **4-22** 19**37**

I last saw him alive on **4-21** 19**37** Death is said to have occurred on the date stated above, at **159th St.**

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

Carcinoma of larynx mucous membrane

Date of onset

Other contributory causes of importance: **K56**

Name of operation **Excision** Date of **4-16-37**

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 **Beason B. Kellogg**, M. D.

(Address) **3427 - Washington**

