

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

NOV 22 1937

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

Do not use this space.

1. PLACE OF DEATH

County Phelps
 Township St James
 City (No., St. Ward)

Registration District No. 678
 Primary Registration District No. 1704

File No. 38486
 Registered No.

2. FULL NAME

Reeves Infant Son of Mr. & Mrs. Wm. F. Reeves

(a) Residence, No. St. Ward. (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 Male 4. COLOR OR RACE white 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) 11-6-37

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none
 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 James Hospital
St James, Mo

13. NAME Wm F Reeves

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

15. MAIDEN NAME Freda Delcour

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

17. INFORMANT (ADDRESS) Wm F Reeves
Bourban

18. BURIAL, CREMATION, OR REMOVAL
 PLACE New Rock Cem DATE 11-7 1937

19. UNDERTAKER (ADDRESS) W E Richlender
St James Mo

20. FILED 11-8-1937 Mrs. W. A. Dook
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-6 1937

22. I HEREBY CERTIFY, That I attended deceased from 11/6 1937, to 11/6 1937

I last saw him alive on 11/6 1937. Death is said to have occurred on the date stated above, at 7 P m.

The principal cause of death and related causes of importance were as follows:
Premature Birth Date of onset

Other contributory causes of importance:
Marginal Placenta Previa

Name of operation no Date of no
 What test confirmed diagnosis? no Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury, 19...
 Where did injury occur? no (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury no
 Nature of injury no

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) E. A. Scott M. D.
 (Address) St James Hospital, St James, Mo

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

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Do not use this space.

1. PLACE OF DEATH
 (a) County Chelapa Registration District No. 678
 (b) Township St James Primary Registration District No. 3904 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Infant son of me & Mrs Wm F Reeves
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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) mf

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-6-1937

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, <u>3</u> hrs. or <u>3</u> min.
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OCCUPATION

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

9. Industry or business in which work was done, as 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 _____

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

MOTHER

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 1-9-38 Mo. W. J. Souk Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-6-1937

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:

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 _____, 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 E. A. Scott _____, M. D.
 (Signed) St James Hoop (Address) _____

SUPPLEMENTARY

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

CAUTION: BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

