

DEC 16 1937

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

Do not use this space.

41100

1. PLACE OF DEATH

County *Dell Co*

Registration District No. *341*

Township *Benton*

Primary Registration District No. *5334*

City *Buffalo* (No. *1*)

St. _____ Ward _____

2. FULL NAME

Evangelin V. 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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb - 17 - 1883*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *54 8 2*

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

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) *Springfield Kansas*

13. NAME *Thomas Cooper*

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

15. MAIDEN NAME *Synthia Stout*

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

17. INFORMANT (ADDRESS) *H. A Reed Buffalo Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Kenley* DATE *Oct - 20 - 37*

19. UNDERTAKER (ADDRESS) *B. Jones Buffalo*

20. FILED *11/10* 19 *7* *H. A Reed* Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from *Oct. 15*, 1937, to *Oct. 18*, 1937

I last saw h. e. s. alive on *Oct. 18*, 1937 Death is said to have occurred on the date stated above, at *8:30* a. m.

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

Peritonitis
Intestinal obstruction

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? *No* If so, specify _____

(Signed) *G. R. Mayer*, M. D.

(Address) *380 1/2 E. Com. Springfield Mo*

Review 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.

129

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

41100

Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 241
(b) Township 7, Benton Primary Registration District No. 5334
(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.

Registered No.

2. PRINT FULL NAME Evangelina V. Lind

(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
34 8 2

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 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 19, 1937

22. I HEREBY CERTIFY, That I attended deceased from Oct 18, 1937 to Oct 18, 1937

I last saw her alive on Oct 18, 1937. Death is said to have occurred on the date stated above, at 8 A.M.

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

Peritonitis
Parturition Obstructive

Date of onset

Other contributory causes of importance:

Name of operation W Date of

What test confirmed diagnosis? W 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) G. A. Mayer, M. D.

(Address) 580 1/2 E. Commerce
Springfield Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

