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

Do not use this space.

2866

1. PLACE OF DEATH

County Pettis — Registration District No. 668 — File No.

Township — Primary Registration District No. 3032 — Registered No. 513

City Sedalia (No. ..... St. ..... Ward)

2. FULL NAME John J Reed

(a) Residence. No. 513 W Cooper St., ... Ward. (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	Col	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 25 1876

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	52	1	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dept Constable
(b) General nature of industry, business, or establishment in which employed (or employer) +
(c) Name of employer C H Reams

9. BIRTHPLACE (CITY OR TOWN) Newarlins La
(STATE OR COUNTRY) dont no

PARENTS

10. NAME OF FATHER John J Reed
11. BIRTHPLACE OF FATHER (CITY OR TOWN) dont no
(STATE OR COUNTRY) dont no
12. MAIDEN NAME OF MOTHER dont no
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) dont no
(STATE OR COUNTRY) dont no

14. INFORMANT Delia Reed
(Address) Sedalia Mo

15. FILED 1/10, 1929 J G Love REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/10 1929

17. I HEREBY CERTIFY, That I attended deceased from 10/18/26, 19..., to 1/10/29, 19..., that I last saw h... alive on 1/10/29, 19..., and that death occurred, on the date stated above, at 5 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
131
99 A
Chronic (duration) yrs. 2 mos. 12 ds.

CONTRIBUTORY (SECONDARY) Interstitial nephritis
(duration) yrs. mos. ds.

129 a

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? place death
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? test for same
(Signed) L. F. Brooks, M. D
1/10/29, 19 (Address) Sedalia, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Sedalia Mo	Jan 13 1929
20. UNDERTAKER	ADDRESS
F D Ferguson	Sedalia

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.

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