MAR 23 1929

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

Do not use this space.

9543

10 3 8

1. PLACE OF DEATH

County: Boone — Registration District No.: 73 — File No.: 89

Township: — Primary Registration District No.: 3006 — Registered No.:

City: Columbia (No. ..... St. ..... Ward)

2. FULL NAME: Mrs. Laura E. Reed

(a) Residence. No. 214 3rd ave 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)
Female	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: J M Reed

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Oct 14-1870

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	57	5	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

2 35

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Callaway Co Mo

PARENTS

10. NAME OF FATHER: William Abbott

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Boone Co Mo

12. MAIDEN NAME OF MOTHER: Matilda Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Callaway Co Mo

14. INFORMANT: Mrs Chas H. Trimble
(Address) R1 - Columbia Mo

15. FILED 3-18, 1929 Beatrice Grubbs REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mar 17 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 1:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis

131 Endocarditis

9.9.B (duration) yrs. 8 mos. ds.

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

1290

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? Urinary Analysis

(Signed) A. C. Hoffmann, M.D.

3/19, 1929 (Address) 2 S. 9th

*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
New Salem Cemetery	Mar 19 1929

20. UNDERTAKER	ADDRESS
B F Baker	Columbia

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.