

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

Do not use this space.

29618
8806

1. PLACE OF DEATH

County.....

Registration District No. *783*

Township.....

Primary Registration District No. *03*

City *St. Louis* (No. *3652* *Lierman Ave*)

File No.

Registered No.

St.

Ward)

2. FULL NAME *Suzanne Rosetta Reed*

(a) Residence. No. *3652 Lierman Ave*, *15* 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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female

White

Married

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

Dr. Oscar R. Reed

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

Nov. 22, 1892

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

36

9

6

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

St. Louis Missouri

10. NAME OF FATHER

John F. Dueringer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Ospe Girardin MO

12. MAIDEN NAME OF MOTHER

Suzanne Zittel

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Ashley Illinois

14.

INFORMANT

(Address)

Dr. O. R. Reed 3652 Lierman Ave

15.

FILED

Wm. C. Carter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 28* 19 *29*

17.

I HEREBY CERTIFY, That I attended deceased from

Nov 21, 19*26*, to *Aug 28*, 19 *29*

that I last saw him alive on *Aug 27*, 19 *29*, and that death occurred, on the date stated above, at *6:30 A. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of Lungs

(duration) *5* yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Tuberculosis of Spleen

(duration) *3* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *Sputum + XRay*

(Signed) *J. G. Dredel* M. D.

Aug 28, 19 *29* (Address) *675 Mission Street St. Louis*

*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

Oak Grove Mausoleum 8/30 1929

20. UNDERTAKER

ADDRESS

Ch. Hoffmeister 114 S. Broadway

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.

RECORD

