

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

Do not use this space.

1946

File No. _____
Registered No. 11
St. _____ Ward _____

PLACE OF DEATH

County Mississippi Registration District No. 566
Township Paragould Registration District No. 5762
City Reeater (No. _____)

2. FULL NAME

Geneva Reeves

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 15, 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2 | 0 | 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER Fronzie Reeves

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

12. MAIDEN NAME OF MOTHER Ferry Ward

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

14. INFORMANT Gas. J. Reeves
(Address) Reeater, Mo.

15. FILED _____ 19 _____ REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH 7RM

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/26 1930

17. HEREBY CERTIFY, That I attended deceased from Jan 21st, 1930, to Jan 26th, 1930 that I last saw h. m. alive on Jan 26th, 1930, and that death occurred, on the date stated above, at 7:10 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
IIA
IDR
106A (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) La Grip & cold (duration) _____ yrs. _____ mos. _____ ds.

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

8. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Joe R. Lee M. D.
, 19 Charleston 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 L.O.D. F DATE OF BURIAL 1/27 1930

20. UNDERTAKER Louis Hud. Co ADDRESS Charleston Mo

N. B. - If the cause of death is not stated, the physician should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is also important.

SEP 19 1928

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Miss
Township Liguappity
City..... (No..... St..... Ward)

Registration District No. 566
Primary Registration District No. 5762

File No.....
Registered No. 11

2. FULL NAME

Geneva Reeves

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>S</u>
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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. ormin.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....
(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT.....
(Address)

15. FILED Mar 12th 1930 J S Vernon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 26 1930

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.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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?.....

(Signed)....., M. D.

, 19 (Address)

*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
	19

20. UNDERTAKER	ADDRESS
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THIS IS A SUPPLEMENTARY RECORD
 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-1946