

1930

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

Do not use this space.

6128

1. PLACE OF DEATH

County St. Charles Registration District No. 760
Township Forest Primary Registration District No. 5999
City Wentzville (No. _____) St. _____ Ward _____

File No. _____
Registered No. 124

2. FULL NAME Dr. James A. Reid

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 24 mos. 0 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

Clara Reid

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 10 - 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
59 6 1

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Capr. Graham, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER James Reid

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER English

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Don't know

14. INFORMANT James B. Reid
(Address) Kansas City, Mo.

15. FILED 3/10/30 J. M. Glutins REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 11 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1930, to Feb 11 1930, that I last saw him alive on Feb 11 1930, and that death occurred, on the date stated above, at 11 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Central Thrombosis
(Apoplexy)

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

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Blumhardt M. D.

Feb 11 1930 (Address) Forestll 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 _____

20. UNDERTAKER _____ ADDRESS _____

19

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

IN SENATE,
January 15, 1930.

REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
FOR THE YEAR 1929.

ALBANY, N. Y.:
JAMES B. WARD, STATE PRINTER,
1930.

**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 St. Charles Registration District No. 760 File No. _____
 Township Union Primary Registration District No. 3999 Registered No. 129
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Dr. James A. Reid
 (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 M 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.

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)

PARENTS
 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) _____

FILED 3/10/30 Dr. J. M. Jenkins (REGISTRAR)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 11 19 30

17. I HEREBY CERTIFY That I attended deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ 19 _____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

_____ (duration) _____ yrs. _____ mos. _____ ds.
 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 Private Cemetery DATE OF BURIAL Feb 14 19 30
St. Neustyville

20. UNDERTAKER N. A. Ball ADDRESS Neustyville

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY UNDERSTOOD BY THE GENERAL PUBLIC

S-6/28