

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

Do not use this space.

File No. **10694**
 Registered No. _____

1. PLACE OF DEATH

62 County Madison
 Township Park
 City _____ (No. _____)

Registration District No. 638
 Primary Registration District No. 5724

2. FULL NAME Clougo Reed

(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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 7, 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
54 | 10 | 7

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Laborer 237
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) French Mills, Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER John Reed

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

12. MAIDEN NAME OF MOTHER Jane Pickett

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

14. INFORMANT Thos Bailey
 (Address) Frederickton, Mo. R. 3

15. May 21 1931
 REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 11 1931

17. I HEREBY CERTIFY, That I attended deceased from May 3rd, 1931, to May 11, 1931, and that I last saw him alive on May 7, 1931, and that death occurred, on the date stated above, at 5:24 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart failure
11A
112

CONTRIBUTORY Flu & Asthma
 (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) M. B. Parker, M. D.
3/11, 1931 (Address) Frederickton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDE, or HOMICIDE.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Dale Grange, Mo. DATE OF BURIAL May 12 1931

20. UNDERTAKER None ADDRESS _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
 APR 24 1931
 53-10-4

1942

1/2

1/2

1/2

1/2

1/2

1/2

1/2

1/2

1/2

1/2

1/2



**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 Madison Registration District No. 538 File No.
 Township Orchard Primary Registration District No. 3-726 Registered No.
 City (No.) St. Ward)

2. FULL NAME Alonzo Reed
 (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

MEDICAL CERTIFICATE OF DEATH

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) May 7 - 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 10 14

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)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 11 1931

17. I HEREBY CERTIFY, That I attended deceased from to 19....., and 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:

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.

14. INFORMANT (Address) 19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 15. Mar 11 1931 Orchard REGISTRAR ADDRESS 19

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 classified. Exact statement of OCCUPATION is very important.

AGE shown by statute required. PHYSICIANS SHOULD STATE

SUPPLEMENTARY

46991-5