

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Waver  
City W. E. Mo.

Registration District No. 390  
Primary Registration District No. 1000  
(No. Wesley Hosp)

File No. 16611  
Registered No. 2106  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

James Paul Reed  
(a) Residence, No. 5207 Wesley Hospital 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 male 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb-1-1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
42 4F 2 13

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Salesman  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Auto Parts  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Colo

MOTHER FATHER  
13. NAME James P. Reed

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

15. MAIDEN NAME Frances E. Burnett

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT Ruby Reed  
(ADDRESS) 5207 Gladstone

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Duress - Colo DATE May-14-33

19. UNDERTAKER Mr. C. L. Foster  
(ADDRESS) 918 Broadway Ave

20. FILED May 15 1933 M. M. Erdman  
Asst. Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May-14-1933

22. I HEREBY CERTIFY, That I attended deceased from May 9, 1933, to May 14, 1933  
I last saw him alive on May 13, 1933. Death is said to have occurred on the date stated above, at 4:30 m.  
The principal cause of death and related causes of importance were as follows:

Uremic Coma  
1933  
1933  
Other contributory causes of importance: \_\_\_\_\_

Name of operation None Date of \_\_\_\_\_  
What test confirmed diagnosis clinical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_

(Signed) R. B. Coffey, M. P.  
(Address) 1103 Gaud

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.

7-2 CH 3359

ARTICLE 11. OCCUPATIONAL PHYSICIANS.

Section 11.01. The Board of Occupational Physicians shall be composed of five members, to be appointed by the Governor, one of whom shall be the Chairman. The Board shall have the honor and privilege of the robes of the State Bar of Texas. The Board shall hold office for a term of five years, and shall be eligible for reappointment. The Board shall meet at such times and places as it may determine. The Board shall have the right to subpoena witnesses and to take such other action as may be necessary to carry out its duties. The Board shall have the right to make and enforce such rules and regulations as may be necessary to carry out its duties. The Board shall have the right to suspend or expel any member who is guilty of misconduct. The Board shall have the right to suspend or expel any member who is guilty of neglect of duty. The Board shall have the right to suspend or expel any member who is guilty of incompetence. The Board shall have the right to suspend or expel any member who is guilty of unbecoming conduct. The Board shall have the right to suspend or expel any member who is guilty of any other offense which may be deemed to be in the best interests of the public. The Board shall have the right to suspend or expel any member who is guilty of any other offense which may be deemed to be in the best interests of the public.

11.01

**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 Jackson Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Township Kaw Primary Registration District No. \_\_\_\_\_ Registered No. 2106  
 City K 6 mo (No. Wesley Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 5207 Gladstone 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 Male 4. COLOR OR RACE \_\_\_\_\_ 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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
42

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_

11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED May 15 1933 M. M. Cerone Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 14 1933

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_ Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Wegner's coma Date of onset \_\_\_\_\_

Septic renal syndrome

Other contributory causes of importance:

alcoholism?

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) K. K. Cerone, M. D.

(Address) \_\_\_\_\_

SUPPLEMENTARY

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

5-14611

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