

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

Do not use this space.
32932 ✓

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.

NOV 10 1933

1. PLACE OF DEATH
 County Jackson Registration District No. 398
 Township Blair Primary Registration District No. 3049
 City K.C. 7th (No. 2nd St. Sanitarium) St. _____ Ward _____

2. FULL NAME Robert Reader
 (a) Residence. No. 217 So. Hardy, Fairmont Mo.
 (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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-27-1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
47 6 12

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-9-1933

17. I HEREBY CERTIFY, That I attended deceased from _____, 1933, to _____, 1933, that I last saw h. _____ alive on _____, 1933, and that death occurred, on the date stated above, at 12:20 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Polycythemia Vera
14.30 (duration) _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Nephroses
 (duration) _____ yrs. _____ mos. _____ ds.

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

10. NAME OF FATHER Phares Reader

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

12. MAIDEN NAME OF MOTHER Mary Mc Kinley

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

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 Clinical & Laboratory
 (Signed) Clifford Allen, M. D.
 Oct 7, 1933 (Address) 10307 Indep Ave KC 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.

14. INFORMANT Mrs Ruth Reader DATE OF BURIAL 10/10/33
 (Address) 217 So. Hardy, Fairmont Mo.
 15. FILED Oct 9, 1933 Dr. F. L. Cook REGISTRAR
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL W. Washington
 20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo

PARENTS

