

DEC'D FEB 15 1939

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

2929  
Do not use this space.

1. PLACE OF DEATH *Linn* 2  
(a) County *Linn* Registration District No. *494*  
(b) Township *Brookfield Mo.* Primary Registration District No. *3020*  
(c) City *Brookfield Mo.* (d) Street No. *9* Registered No. *9*  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
2. PRINT FULL NAME *James Lloyd Reed*  
(a) Residence, No. *115 West Robert* St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## 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 *Emma Jane Reed*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Dec. 75*

7. AGE YEARS *76* MONTHS *1* DAYS *11* If LESS than 1 day, .....hrs. or .....min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Printer*  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) *Dec 1935* 11. Total time (years) spent in this occupation *50*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Milan Mo.*

FATHER 13. NAME *Harrison Reed*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER 15. MAIDEN NAME *Sarah Ducky*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *Alberta Snider*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Milan Mo.* DATE *Jan 28 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *James P. Bowden Brookfield Mo.*

20. FILED *Feb 1 39* *Brookfield* Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan. 26 1939*

22. I HEREBY CERTIFY, That I attended deceased from *1937* 19..... to *Jan 26* 1939

I last saw him alive on *Jan. 25 1939* Death is said to have occurred on the date stated above, at *1:41 p.m.*  
The principal cause of death and related causes of importance were as follows:

*myocarditis - chronic* Date of onset *1937*

Other contributory causes of importance: *nephritis and arteriosclerosis*

Name of operation *none* Date of.....  
What test confirmed diagnosis? *clinical* Was there an autopsy? *no*

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? *no*  
If so, specify *W. B. Simpson D.O.* (Signed) *Brookfield, Mo.* (Address)

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.

98, 21

RECEIVED

District Health Officer No. 10

District File Number 10-39-8

Date Filed FEB 8 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

2929

Do not use this space.

1. PLACE OF DEATH

(a) County Linn Registration District No. 496

(b) Township \_\_\_\_\_ Primary Registration District No. 3025

(c) City Brookfield (d) Street No. \_\_\_\_\_ St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James Lloyd Reed

(a) Residence, No. \_\_\_\_\_ St.

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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) \_\_\_\_\_

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	76	1	4	

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

9. Industry or business in which work was done, as 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) \_\_\_\_\_

FATHER

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

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

MOTHER

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

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

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

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19\_\_\_\_

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-26 1939

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

I last saw h. \_\_\_\_\_ 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:

Myocarditis chronic Date of onset \_\_\_\_\_

Nephritis chronic

Arterio Sclerosis

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

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

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) H. B. Simpson, M. D.

(Address) Brookfield Mo

SUPPLEMENTARY

REGISTRARS SMALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Local Registrar.

