

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1487**

FILED JAN 25 1952
BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **187**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 4 Days		d. STREET ADDRESS (If rural, give location) 4517 N. Oak	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research			
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) F c. (Last) Schryer			4. DATE OF DEATH (Month) (Day) (Year) Jan 11 1952
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 20 Oct. 1940
9. AGE (In years last birthday) 11		IF UNDER 1 YEAR Months 2 Days 27	IF UNDER 4 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Grade School	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Carl Schryer		13b. MOTHER'S MAIDEN NAME Doris Paxton	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Doris Schryer ADDRESS NKCLMO
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Postoperative Edema of Brain ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Malignant Tumor of Brain DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1937	
19a. DATE OF OPERATION 1-8-52		19b. MAJOR FINDINGS OF OPERATION Tumor of Cerebellum	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 1-4 1952 , to 1-11 1952 , that I last saw the deceased alive on 1-10 1952 , and that death occurred at 5:20 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE Donald F. Coburn (Degree or title)		23b. ADDRESS 411 Nichols Road	23c. DATE SIGNED 1-11-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 14 Jan 1952	24c. NAME OF CEMETERY OR CREMATORY White Chapel Gardens
24d. LOCATION (City, town, or county) (State) K.C. North Mo.			
DATE REC'D BY LOCAL REG. 1-13-52		REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Waters Funeral Home ADDRESS NKCL

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....

James W. Martin

Signed.....
Student Embalmer

Licensed Embalmer No. 4856

P. O. Address M. C. Moore

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, fact should be so stated above.