

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017212

STATE FILE NUMBER

FILED JUN 2 1959

Registration District No. 29

Primary Registration District No.

Registrar's No. 32

5. 300
1-57

1. PLACE OF DEATH a. COUNTY DE KALB		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY DE KALB	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WEATHERBY		c. CITY OR TOWN WEATHERBY	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) 032	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM ROY REID		4. DATE OF DEATH Month Day Year MAY 23-1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 2-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM WORK		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 70 2 21
11. BIRTHPLACE (City and state or country) WEATHERBY MO		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME JEFFERSON REID		13b. MOTHER'S MAIDEN NAME CAROLINE HOWARD	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 495-26-3965		17. INFORMANT Address Lee Dawn Weatherby, MO	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH bleed suddenly.
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from May 22, 1959 to May 23, 1959 and last saw him alive on May 22, 1959 . Death occurred at 11:55 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Frank W. Williams M.D.		22b. ADDRESS Winstan, MO.	
22c. DATE SIGNED 5-23-59		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE 5-25-59		23c. NAME OF CEMETERY OR CREMATORY ALTA VISTA	
23d. LOCATION (City, town, or county) (State) WINSTON MO		24. FUNERAL DIRECTOR ADDRESS Wingil V. Straup	
25. DATE RECD. BY LOCAL REG. 5-25-69		26. REGISTRAR'S SIGNATURE Karver Davidson	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Special tabular, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Robert F. Poland*

Licensed Embalmer No. *4777*
223 West 3rd
P. O. Address... *Compton, Ill.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.