

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-037158

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 249 Primary Registration District No. 1002 Registrar's No. 5084 STATE FILE NUMBER

FILED OCT 27 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT BY AFFIDAVIT OF Esther Winkelman MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>20 years</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>New Hope Nursing H.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4734 Jarboe</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William A.</u> Middle <u>Reid</u> Last			4. DATE OF DEATH Month <u>Oct.</u> Day <u>10</u> Year <u>1961</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during past 12 months if retired) <u>Dental Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Reid Laboratory</u>	9. AGE (last birthday) <u>81</u> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>Wausau, Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William Abbott Reid</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Winkley</u>	14. NAME OF HUSBAND OR WIFE <u>Helen L. Reid</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs. D. C. Robinson 4710 E 44th Terr. K.C. Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital heart failure & toxic</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>effects of acute upper respiratory</u> DUE TO (c) <u>infection</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Sensitizy</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <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 <u>3-6, 1947</u> to <u>Oct 9 1961</u> and last saw ^{her} him alive on <u>Oct 9, 1961</u> Death occurred at <u>A. m</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Esther Winkelman M.D.</u>		22b. ADDRESS <u>7449 Broadway K.C. Mo</u>	22c. DATE SIGNED <u>10-11-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-12-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Floral Hills Memorial Chapels, Inc.</u>		25. DATE RECD. BY LOCAL REG. <u>10-12-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

1:30 - 5 PM
10:30 - noon
7449 Broadway
St. 3 - 4435
M. J. Jones

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 C. M. Jones

Licensed Embalmer No. 3153

P. O. Address H. C. Jones

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.