

No. 2  
-1/47  
5-17-39

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

FILED MAY 23 1948

Registration District No. \_\_\_\_\_

Primary Registration District No. **4009**

Registrar's No. **247**

1. PLACE OF DEATH:

(a) County: **Andrew**

(b) City or town: **SAYAMAN**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Paranormal mo /**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: \_\_\_\_\_ (Specify whether)

In this community: **Life**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **Andrew**

(c) City or town: **Savannah**  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country: \_\_\_\_\_

3. (a) PRINT FULL NAME: **Walker Reid**

3. (b) If veteran, name war: \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex: **m** 5. Color or race: **W**

6. (a) Single, widowed, married, divorced: **m**

6. (b) Name of husband or wife: **Bessie Irene Reid**

6. (c) Age of husband or wife if alive: **57** years

7. Birth date of deceased: **Dec-19-1874**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>73</b>	<b>4</b>	<b>22</b>	hr. _____ min. _____

9. Birthplace: **Buchanan Co mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation: **Retired Cemetery Sexton**

11. Industry or business: \_\_\_\_\_

12. Name: **Joseph Reid**

13. Birthplace: **un known mo**  
(City, town, or county) (State or foreign country)

14. Maiden name: **SARAH HOWARD**

15. Birthplace: **Maryville Kentucky**  
(City, town, or county) (State or foreign country)

16. (a) Informant: **Mrs Bessie Reid**

(b) Address: **Savannah mo**

17. (a) **Burial** (b) Date thereof: **3-13-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Savannah**

18. (a) Signature of funeral director: **E. C. Breit**

(b) Address: **Savannah mo**

19. (a) **5-15-48** (b) **Kelley Sparks**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **5** day **11**  
year **1948** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **4-6-48**  
\_\_\_\_\_, 19\_\_\_\_, to **5-11**, 19**48**  
that I last saw him alive on **5-11**, 19**48**  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Cancer, Pancreas**

Duration: **6 mo**

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: **4/6/48**

Of operations: \_\_\_\_\_

of autops: **ca of Pancreas i**  
**See Intestines.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence: \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_ (Specify type of place)

While at work? **no** (Specify means of injury)

23. Signature: **Libertus Kelly** (M. D. or other) **no**

Address: **Savannah Mo** Date signed: **5-11-48**

PHYSICIAN

Underline the cause of which death should be charged statistically.

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

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**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 E. C. Breit

Licensed Embalmer No. 2652

P. O. Address Savannah Mo

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.