

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4946

STATE FILE NUMBER

FILED FEB 18 1957

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 434

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital			Length of stay in 1b 2 yrs		d. STREET ADDRESS 801 E Armour		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARRY Middle S.C. Last REID				4. DATE OF DEATH Month January Day 28 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 11 1906		9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10b. KIND OF BUSINESS OR INDUSTRY Chemical Grace Lee Products		11. BIRTHPLACE (City and state or country) Summerville Georgia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Reid				14. MOTHER'S MAIDEN NAME Margaret Carter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1925 304-07-8000		17. INFORMANT Address Mrs Ophelia Reid 801 E Armour			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage into Cervical Spinal Cord Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Guillain-Barré Syndrome DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3 hours 2 weeks 364x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.) 0				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
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 24 Jan 57 to 28 Jan 57 and last saw ^{her} him alive on 28 Jan 57 Death occurred at 8:30 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) William C. Van Buskirk, M.D.				22b. ADDRESS 4th Professional Bldg. KCMo		22c. DATE SIGNED 29 Jan 57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Jan 29 1957	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Park		23d. LOCATION (City, town, or county) Indianapolis Indiana		(State)
24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo				25. DATE RECD. BY LOCAL REG. 1-29-57		26. REGISTRAR'S SIGNATURE Irene Minshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
William C. Van Buskirk

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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 *Thomas A. Smith*.....

Licensed Embalmer No. *492*

P. O. Address... *R.C.M.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.