MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

21321

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No.

Township Kan — Primary Registration District No. 1002 — Registered No. 2664

City Kansas City (No. General Hospital St. Ward)

2. FULL NAME Williams Clay

(a) Residence. No. 1655 Madison St., 3 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	white	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-10-1894

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	33	5	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lather
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Chillicothe
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER James Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Catherine Vanderpool

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Missouri

14. INFORMANT Record Clerk
(Address) Kansas City Gen'l Hosp

15. FILED 7/4, 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-4- 1927

17. I HEREBY CERTIFY, That I attended deceased from 7-2-, 1927, to 7-4-, 1927 that I last saw him alive on 7-4-, 1927, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
Cardiac Decompensation
108
95B
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 101a
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) George C. Lee, M. D
7-4, 1927 (Address) General Hosp. K.C. Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Utica Missouri	7-5 1927

20. UNDERTAKER	ADDRESS
O. V. Mast	1915 E. 15th City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.