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.

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

SEP 20 1934

Do not use this space.

29607

1. PLACE OF DEATH

County Jackson — Registration District No. 399 — File No. [illegible]

Township ~~Kan~~ — Primary Registration District No. 1002 — Registered No. [illegible]

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

2. FULL NAME John Joseph Williams

(a) Residence, No. 3639 Baltimore St., 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 11 1859

7. AGE: YEARS 74 — MONTHS 8 — DAYS 17 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Inspector for

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. K.C. Water Dept.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

FATHER

13. NAME Michael Williams

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER

15. MAIDEN NAME Catherine Manning

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) Mrs Teresa Williams 3639 Baltimore

18. BURIAL, CREMATION, OR REMOVAL

PLACE Calvary Cem DATE Aug 31 1934

19. UNDERTAKER (ADDRESS) Quirk & Tobin Co. 20 West Linwood

20. FILED 8/30, 1934 M. M. Crowe asst Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 28 1934

22. I HEREBY CERTIFY, That I attended deceased from 6-2, 1934, to 8-28, 1934

I last saw him alive on 8-28, 1934. Death is said to have occurred on the date stated above, at 11:10 P M

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary occlusion	6-1-34
94B	
97	

94A

Other contributory causes of importance:

Generalized arteriosclerosis

Name of operation none Date of

What test confirmed diagnosis? Autopsy Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Allstrio Gusbes, M. D.

(Address) 724 Argyle Bldg