

1937 MAR 9 1939

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

5383
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson Registration District No. 399
(b) Township Raw Primary Registration District No. 1002
(c) City W.C. Mo. (d) Street No. General Hospital #2 Registered No. 582
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Clarence Williams
(a) Residence, No. 2403 Pine St. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-29-1933
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
5 3 4
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc.
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) Mo.
13. NAME Clarence Williams
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okl.
15. MAIDEN NAME Thelma Gordon
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
17. INFORMANT (ADDRESS) Record Clerk General Hospital
18. BURIAL, CREMATION OR REMOVAL PLACE Highland DATE 7/11/39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wabbing Mo. 724 High
20. FILED 7/11/39 W. M. Brown Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-2 19 39
22. I HEREBY CERTIFY, That I attended deceased from 12-28, 1938, to 2-2, 1939
I last saw him alive on 2-2, 1939 Death is said to have occurred on the date stated above, at 5:05 a.m.
The principal cause of death and related causes of importance were as follows:
Internal
Congenital Hydrocephalus
Other contributory causes of importance: 1870
Date of onset
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ 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? 1
If so, specify _____
(Signed) J. C. Brown M. D.
(Address) General Hospital #2

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.

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,

C. H. West

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

C. H. West

Licensed Embalmer No. *2710*

P. O. Address *Kansas City, 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, above space should be left blank.