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

DEC'D SEP 6 1939

28097
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 3 Registration District No. 399
(b) Township or Kaw 2 Primary Registration District No. 1802 Registered No. 3099
(c) City Kansas City (d) Street No. 8th and Grand Ave. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 William Addison
(a) Residence, No. 1214 Armstrong K.C.K. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 3-22-1878
7. AGE: YEARS 61 MONTHS 4 DAYS 6 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Comm. Laborer
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): Missouri

FATHER
13. NAME: George Addison
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

MOTHER
15. MAIDEN NAME: Marie Williams
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

17. INFORMANT (ADDRESS): Maude Crawford 2300 N. 21st St.
18. BURIAL, CREMATION, OR REMOVAL
PLACE West Lawn DATE 8-5, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): R. G. Emb. & Casket 440 State Ave.
20. FILED 8/4, 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 7-28-39, 19

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
I last saw him alive on ....., 19.... Death is said to have occurred on the date stated above, at 1 am m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypertrophy & Dilatation of Heart	
Cerebral Pulmonary Edema	

Other contributory causes of importance: 95 B2

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

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? .....
If so, specify .....
(Signed) Russell W. [illegible], M. D.
(Address) [illegible]

(Licensed Embalmer's Statement on Reverse Side)

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

H B Mann, Registered Apprentice No.

working under my personal supervision.

Signed H B Mann

Licensed Embalmer No. 2410

P. O. Address 1820 E 18 St

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.