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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5779
Registrar's No. 551

Registration District No. 399 Primary Registration District No. 1002

48
3
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town K.C. Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution General Hospital #2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 Hours (Specify whether
In this community 10 year 0 years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48
(a) State Mo (b) County Jackson 3
(c) City or town K City 8 (If outside city or town limits, write "RURAL")
(d) Street No. 1419 Forest (If rural, give location)
(e) If foreign born, how long in U. S. A.? America 0 years.

3. (a) PRINT FULL NAME Tom Williams
3. (b) If veteran, name war no
3. (c) Social Security No. 487-095232
4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Irene Williams
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased Sep (Month) 1 (Day) 1888 (Year)

8. AGE: Years 52 Months 5 Days 1 ~~28~~ If less than one day ___ hr. — min.

9. Birthplace Parris Texas (City, town, or county) (State or foreign country)
10. Usual occupation Labor
11. Industry or business Pipe Shop
MOTHER FATHER
12. Name Dant no
13. Birthplace Texas (City, town, or county) (State or foreign country)
14. Maiden name Hattie Williams
15. Birthplace Texas (City, town, or county) (State or foreign country)
16. (a) Informant Irene Williams
(b) Address 1419 Forest
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-10-41 (Month) (Day) (Year)
(c) Place: burial or cremation West Lawn Cem
18. (a) Signature of funeral director Doyle Bro Funeral Home
(b) Address 1708 Troy
19. (a) 2/7/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 2 year 41 hour 11:40 minute P.M.
21. I hereby certify that I attended the deceased from ___, 19__, to ___, 19__; that I last saw him alive on ___, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart disease
Due to
Due to 93 ~~H~~
Other conditions (Include pregnancy within 3 months of death) 93 ~~H~~
Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury 3
23. Signature [signature] (M. D. or other)
Address K.C. Mo Date signed

(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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3588

P. O. Address K.C. MO.

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

If this body is not embalmed, fact should be so stated above.