

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26537**
Registrar's No. **3225**

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Marys Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **19 days**
(Specify whether
In this community **24 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **4008 Troost**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **JAMES R WILLIAMS**
(b) If veteran, name war **No**
(c) Social Security No. **495-05-630**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **26th** day **August**
year **1942** hour **11:20** minute **P** M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced or **Married**
6. (b) Name of husband or wife **Juanita Williams**
6. (c) Age of husband or wife if alive **22** years
7. Birth date of deceased **Dec 20 1917**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **8-9 1942** to **8-26 1942**
that I last saw **him** alive on **8-26 1942**
and that death occurred on the date and hour stated above.

8- AGE:	Years	Months	Days	If less than one day
	24	8	6hr.min.

Immediate cause of death
Sub-Acute Bacterial Endocarditis

9. Birthplace **Kansas City Mo**
(City, town, or county) (State or foreign country)

Due to
Due to

10. Usual occupation **Office Clerk**

Other conditions (Include pregnancy within 3 months of death)
Artery

11. Industry or business **Stewart Sand & Material**

Physician **Shambaugh & Fenner**

12. Name **Joseph W Williams**

Major findings: Of operations

13. Birthplace **Kansas City Mo**
(City, town, or county) (State or foreign country)

Of autopsy **yes to same**

14. Maiden name **Adelaide Holohan**

22. If death was due to external causes, fill in the following:

15. Birthplace **Kansas City Mo**
(City, town, or county) (State or foreign country)

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....

16. (a) Informant **Mrs Juanita Williams**
(b) Address **4008 Troost**

(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?

17. (a) **Calvary** (b) Date thereof **Aug 29 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(Specify type of place)
While at work? (e) Means of injury.....

(c) Place: burial or cremation **Calvary Cemetery**

23. Signature **H. A. Owens** (M. D. or other) **MO**
Address **1029 Rialto** Date signed **8-27-42**

18. (a) Signature of funeral director **Wm. M. Gubin Co**
(b) Address **20 West Linwood**

19. (a) **8-28-42** (b) **M. M. Cronin**
(Date received local registrar) (Registrar's signature)

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

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.....

John J. Courroy....., Registered Apprentice No. *307*
working under my personal supervision.

Signed..... *Harold Perry*.....

Licensed Embalmer No. *4097*.....

P. O. Address.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 3225

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(c) Name of hospital or institution:
St. Mary's Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME James R Williams

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: 34 Years Months Days If less than one day..... hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 10242 (b) M. M. Crow (Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

20. DATE OF DEATH: Month Aug day 26 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death: acute myocarditis

Due to.....

Due to.....

Other conditions: thrombosis of femoral artery (Include pregnancy within 3 months of death)

Major findings: 918 Of operations.....

Of autopsy.....

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?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature H. H. Owens (M. D. or other) MD

Address 1084 Realty Bldg Date signed 9-30-42

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

5-26537