

S. No. 2
M-2-43
6-17-36
X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31038
State File No. 3314
Registrar's No.

FILED SEP 21 1943

Registration District No. 149 Primary Registration District No. 102

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

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:
General Hospital # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9-2-43, 3:15
In this community 18 yrs.
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. 1024 Virginia
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME WALTER J. WILLIAMS

3. (b) If veteran, name war no 3. (c) Social Security No. None

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

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

7. Birth date of deceased December 25 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 8 9 1 hr. min.

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

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER { 12. Name Walden Williams

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

14. Maiden name Amanda

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

16. (a) Informant Record Clerk

(b) Address General Hospital # 2

17. (a) Burial (b) Date thereof 9-8-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wines In Cemetery

18. (a) Signature of funeral director Adams Bros.
(b) Address 2000 E. 12th K. C. Mo.

19. (a) 9-11-43 (b) J. E. Brown, Dep.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 2
year 1943 hour 3:15 minute P. M.

21. I hereby certify that I attended the deceased from 9-3-43 to 9-3-43
that I last saw him alive on September 3, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Failure Duration _____

Due to Hypertensive Heart Disease

Due to g3d

Other conditions (include pregnancy within 3 months of death) _____

Major findings: 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) _____
(to) (Specify cause of injury)

23. Signature J. E. Brown (M. D. or other) _____
Address Gen. Hosp. #2 - 602 E. 22 Date signed 9-9-43

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

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.....

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.