

FILED JUL 8 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20944**
2702
Registrar's No.

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **701 W. 16th**
at home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **ANNIE R. WILLIAMS**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **NONE**

4. Sex **Female** 5. Color of hair **White** 6. (a) Single, widowed, married, divorced **widow**
6. (b) Name of husband or wife **unk** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **May - 26 - 1867**
(Month) (Day) (Year)

8. AGE: Years **77** Months **1** Days **1** If less than one day hr. min.

9. Birthplace **Mt Sterling Ky**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **Ignatius - Johnson**
13. Birthplace **Lexington - Ky**
(City, town, or county) (State or foreign country)
14. Maiden name **Anna M. Duley**
15. Birthplace **Lexington - Ky**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr Virgil Williams**

(b) Address **701 W - 16th - Kc Mo**

17. (a) **Burial** (b) Date thereof **6-29-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Barry Mo**

18. (a) Signature of funeral director **Morton Pansue A**

(b) Address **North Park City Mo**

19. (a) **6-28-44** (b) **D. E. Blum**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
(c) City or town **Kansas City Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **701 West 16th St Kc.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **27** 2h
year **1944** hour **4:50** minute **P.M.**

21. I hereby certify that I attended the deceased from **March 12**, 1944, to **June 27**, 1944,
that I last saw her alive on **June 27**, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death
Acute cardiac decompensation
Pulmonary edema

Due to **Chr Valvular Insufficiency** 4 yrs.
Due to

Other conditions **92 d.**
(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) (e) Means of injury _____

23. Signature **Dr. Council** (M. D. or other)
Address **708 W 17th St** Date signed **6/28/44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.