

FILED SEP 7 1949
Registration District No. **1002**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH

(a) County **JACKSON**
(b) City or town **JACKSON, MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
HOME 1114 E. 16th
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **30 YRS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME

ANNIE WILLIAMS

3. (b) If veteran, name war **NO**

3. (c) Social Security No. **DONT KNOW**

4. Sex **FE** 2

5. Color or race **NEGRO**

6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **FRANK WILLIAMS**

6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **12 25 1888**
(Month) (Day) (Year)

8. AGE: Years **55** Months **8** Days **0** If less than one day hr. min.

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

10. Usual occupation **HOUSEWIFE**

11. Industry or business **HOME**

MOTHER FATHER
12. Name **DONT KNOW**
13. Birthplace **DONT KNOW**
(City, town, or county) (State or foreign country)
14. Maiden name **DONT KNOW**
15. Birthplace **DONT KNOW**
(City, town, or county) (State or foreign country)

16. (a) Informant **FRANK WILLIAMS (HUSBAND)**
(b) Address **1114 E. 16th KEMO**

17. (a) **BURIAL** (Burial, entombment, or removal) (b) Date thereof **8-29-44**
(Month) (Day) (Year)

(c) Place: burial or cremation **HIGHLAND**

18. (a) Signature of funeral director **Elizabeth Greenstreet**
(b) Address **1819 E. 15th KEMO**

19. (a) **8-28-44** (b) **P. E. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **JACKSON**
(c) City or town **K.C. MO.** 48
(If outside city or town limits, write "RURAL")
(d) Street No. **1114 E. 16th** 2
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

23. DATE OF DEATH Month **8** day **25**
year **1944** hour minute M.

21. I hereby certify that I attended the deceased from **7-30-44** to **8-25-44**
(2) ~~8-25~~ 19 ~~44~~ to **8-25-1944**
that I last saw her alive on **8-25-1944**
and that death occurred on the date, and hour stated above.

Immediate cause of death **cardiac insufficiency** Duration
6 a.m. of 8/25/44
Due to **48 a.m.**

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations **NO operation** PHYSICIAN
release under protest Underline the cause to which death should be attributed.

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) Manner of injury **D**
23. Signature **P. E. Brown** (M. D. or other)
Address _____ Date signed _____

888-22
MATTIE WARD
0 8 22
AAA ADM

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 *Wm G. Flynn*

Licensed Embalmer No. *42383*

P.O. Address *1819 E. 15th Ken*

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.