

FILED OCT 24 1944

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: General Hospital No. 2 0
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 6/23/44-8/30/44
(Specify whether
 In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
 (d) Street No. 562 Cottage Lane 8
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME Ralph Williams

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

4. Sex M 5. Color or race N 6. (a) Single, widowed, married, divorced 0 Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive 11 years 1882

7. Birth date of deceased. June 11 1882
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>2</u>	<u>19</u>	hr. min.

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

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Charles Williams

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

14. Maiden name Martha

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 10/11/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Linda, Mo.

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

(b) Address 1129 ...

19. (a) 10-11-44 (b) W. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH Month 8 day 30
1944 year hour 1 minute 00 P. M.

21. I hereby certify that I attended the deceased from June 23, 1944 to August 30, 1944,
 that I last saw him alive on 19
 and that death occurred on the date and hour stated above.

Immediate cause of death Far advanced Pulmonary Tbc.
 Duration _____

Due to _____

Due to _____

Other conditions 1381
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 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? _____

While at work? No Means of injury ...

23. Signature W. E. Brown (M. D. or other) _____
Address Spivey Hwy #2 600823 Date signed 9/1/44

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *J. J. Marlowe*
Licensed Embalmer No. 3994
P. O. Address 3503 Highland

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

State File No. _____
Registrar's No. 4096

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 149

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 Kansas City
(c) Name of hospital or institution: Gen. Hosp. #2
(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 Ralph Williams
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex _____ 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 _____ year _____
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: 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) Removal (b) Date thereof _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-11-44 (b) T. C. Brown
(Date 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: Aug. 30
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____

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)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL COPY

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

1913-1914
MAY 10 1914

33499