. S. No. 2
0M—5-48
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5381

FILED MAR 7 1945

Registration District No. 7 1945 Primary Registration District No. 1002 Registrar's No. 864

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 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2-16-45-2-17-45 (Specify whether
In this community 2 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 38

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2012 E. 12th St. 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME CHARLES WILLIAMS

3. (b) If veteran, name war None

3. (c) Social Security No. 515-03-7245

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife TeMarie Williams

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased ~~November~~ Oct (Month) 14 (Day) 1893 (Year)

8. AGE: Years 51 Months 4 Days 3 If less than one day hr. min.

9. Birthplace Topeka (City, town, or county) Kansas 1 (State or foreign country)

10. Usual occupation Cab Driver

11. Industry or business Palace Cab

FATHER
12. Name Andrew Williams
13. Birthplace (City, town, or county) Unknown 9 (State or foreign country)

MOTHER
14. Maiden name Alice Rouce
15. Birthplace (City, town, or county) Unknown 9 (State or foreign country)

16. (a) Informant Record Clerk
(b) Address Gen. Hosp. #2

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 2/21/45 (Month) (Day) (Year)
(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director Watkins Bros
(b) Address 1729 Lydia

19. (a) 2-21-45 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 17 year 1945 hour 12:45 minute A M.

21. I hereby certify that I attended the deceased from February 16, 1945, to February 17, 1945 that I last saw him alive on February 16, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Basal Cerebro Vascular Hemorage — Duration

Due to Hypertension

Due to 8 3a

Other conditions Renal Tumor (unqualified)
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other) 19
Address Gen. Hosp. #2 - 64622 Date signed 2-[illegible]-45

(Licensed Embalmer's Statement on Reverse Side)

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.