

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:  
K. C. General Hospital No. 10  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 mins.  
 (Specify whether  
 In this community 3 min  
 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. 723 Proost  
 (If rural, give location)  
 (e) Citizen of foreign country? 0  
 (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Infant of Edward & Lesia Williams  
Williams Infant  
 3. (b) If veteran, \*\*\*\*\* name war \_\_\_\_\_  
 3. (c) Social Security No. \*\*\*\*\*  
 4. Sex Male 5. Color of race White  
 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 October 11 1945  
 (Month) (Day) (Year)  
 8. AGE: Years Months Days If less than one day  
0 0 0 3 min  
 hr. min.

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month Oct. day 11  
 year 1945 hour 3 minute 53 P.M.  
 21. I hereby certify that I attended the deceased from Oct. 11 1945 to 10-11 1945  
 that I last saw him alive on 10-11 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Congenital absence of right cerebral hemisphere (Partial) Duration \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Kansas City, Missouri  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Infant  
 11. Industry or business \_\_\_\_\_  
 12. Name Edward Williams  
 13. Birthplace Missouri  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Lesia Shepard  
 15. Birthplace Missouri  
 (City, town, or county) (State or foreign country)  
 16. (a) Informant Dr. Edward Williams  
 (b) Address Kansas City, Missouri  
 17. (a) Burial (b) Date thereof 10-13-45  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Green Lawn Cemetery  
 18. (a) Signature of funeral director rs. C. L. Forster  
918-20 Brooklyn  
 (b) Address \_\_\_\_\_  
 19. (a) 10-12-45 (b) Thereldine Holmes  
 (Date received local registrar) (Registrar's signature)

Major findings: 157C  
 Of operations \_\_\_\_\_  
 Of autopsy See above  
 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? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_  
 23. Signature Clark W. Seely (M.D. or other)  
 Address Med. Dir. Gen'l Hosp Date signed 10-12-45

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

18  
3  
8

**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.....

working under my personal supervision.

....., Registered Apprentice No. ....

Signed *JOE B. Yoder*

Licensed Embalmer No. *4173*

P.O. Address *916 Brooklyn*

**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.**

*R.C. Mo*