

FILED JUN 20 1946 STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

2491

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: 3150 MERCIER 1  
(d) Length of stay: In hospital or institution 16 hours  
In this community 16 hours

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 3150 Mercier  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME INFANT WILLIAMS

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

4. Sex Female 5. Color or race colored 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased MARCH 17 46

8. AGE: Years Months Days If less than one day 16 hr. min.

9. Birthplace KANSAS city MISSOURI

10. Usual occupation infant

11. Industry or business

12. Name FORMAN WILLIAMS

13. Birthplace PINE BLUFF ARKANSAS

14. Maiden name ROWENA JONES

15. Birthplace INDEPENDENCE MISSOURI

16. (a) Informant MRS. ROWENA WILLIAMS

(b) Address 3150 MERCIER

17. (a) retained (b) Date thereof 3-17-46

(c) Place: burial or cremation Retained for scientific purposes at Kansas City

18. (a) Signature of funeral director College of Osteopathy and Surgery  
(b) Address 6-5-46 (c) Registrar's signature Geraldine Holmes

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 17 year 1946 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from 3:30 AM 3-17-1946 to 7:30 PM 3-17-1946 that I last saw her alive on 4:30 AM 3-17-1946 and that death occurred on the date and hour stated above.

Immediate cause of death Subarachnoid hemorrhage

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Subarachnoid hemorrhage

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?

(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 Frank T. Machover (M. D. or other) P.O. Address 207 Dorfield Ave. N.C. Mo. Date signed 6-4-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

---

---

**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.**