

FILED NOV 28 1947

State File No. _____

Registration District No. 280

Primary Registration District No. 5-95-9

Registrar's No. 78

1. PLACE OF DEATH:

(a) County Platte County
 (b) City or town Rural *Fair*
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 3
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution none (Specify whether)
 In this community Few hours
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State KANSAS (b) County Leavenworth
 (c) City or town Leavenworth
 (If outside city or town limits, write "RURAL")
 (d) Street No. 402 N. 4th Street
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November Day 18
 year 1947 hour _____ minute _____ M.

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

Immediate cause of death: Gun shot wound in the head by a 22 Cal. Rifle.
 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:
 (c) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (d) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (e) 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 3
 23. Signature Tom H. Hulitt Coroner
 (M. D. or other)
 Address Platte City mo Date signed 11-19-47

3. (a) PRINT FULL NAME Robert L. Williams

3. (b) If veteran, name war W.W. 11 3. (c) Social Security No. 512-26-1297

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

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: January 24, 1940
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
17 9 24 hr. _____ min.

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

10. Usual occupation Soldier U.S. Army
 11. Industry or business " " " "

12. Name Raymond Williams

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

14. Maiden name Cecil Cuning

15. Birthplace Jefferson Co. Kansas
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Cecil Towns

(b) Address Leavenworth, Kansas

17. (a) Leavenworth, Kansas thereof Nov. 19, 1947
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery Fort Leavenworth Ks.

18. (a) Signature of funeral director Sexton funeral Chapel

(b) Address Leav. Kansas 2nd & 1st
 19. (a) 11-19-47 (b) Alpha Rollins
 (Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

ADDITIONAL SURVEILLANCE INFORMATION REQUESTED

DEC 8 1947

NOV 28 1947

DISTRICT HEALTH OFFICE
Canton, Mo.

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 ~~me~~.....

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

Signed Thos. L. Lister.....

Licensed Embalmer No. 3003.....

P. O. Address Leawards, Kansas.....

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.

Registration District No. 240

Primary Registration District No. 591-9

1. PLACE OF DEATH:

(a) County Platte county
(b) City or town Platte
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 Robert L. Williams

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive

7. Birth date of deceased Jan 2 1918
(Month) (Day) (Year)

8. AGE: Years 17 Months 9 Days 1
If less than one day hr. min.

9. Birthplace Kansas
(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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

13. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (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) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Year 1947 hour 11 minute 15 M.

21. I hereby certify that I attended the deceased from
that I last saw him alive on
and that death occurred on the date and hour stated above.
Immediate cause of death

Duration

Due to
Due to

Other conditions (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) accident
(b) Date of occurrence
(c) Where did injury occur? Stirling mo (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 Tom H. Hulitt (M.D. or other) Coroner
Address Platte City, Mo. Date signed

SUPPLEMENTARY

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

