

THE DIVISION OF HEALTH OF MISSOURI
FILED MAY 27 1949 STANDARD CERTIFICATE OF DEATH

State File No. 16219
2122

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>18 months 6 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>338 Spruce</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital #1</u>			d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIAM</u> b. (Middle) <u>H.</u> c. (Last) <u>WHITEHEAD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5 13 49</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 14 1885</u>	9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of adult life, even if retired) <u>Paper Hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Joseph Whitehead</u>		13b. MOTHER'S MAIDEN NAME <u>Subman</u>	14. NAME OF HUSBAND OR WIFE <u>Shada Whitehead</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Miss Leah Farley</u> ADDRESS <u>338 Spruce</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Benign hypertrophy of prostate</u> DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>WLDX</u>					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-7</u> , 19 <u>49</u> , to <u>5-13</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>5-13</u> , 19 <u>49</u> , and that death occurred at _____ m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Wm. W. Hart</u> (Degree or title) <u>MD</u>			23b. ADDRESS <u>Sen. Hoop #1</u>		23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>5-14/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wendell Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Phillipburg Kansas</u>	
DATE REC'D BY LOCAL REG. <u>5-14-49</u>	REGISTRAR'S SIGNATURE <u>Geraldine Holmead</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. McD</u> ADDRESS		

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
John B. Camp

Signed.....
Student Embalmer

Licensed Embalmer No.....
2955

P. O. Address.....
H.C. 9th

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.