

FILED JUL 8 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

19504

State File No.

2833

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		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>3 Months</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>			6 48 5
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>306 South Belmont</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>William</u>		b. (Middle) <u>R.</u>		c. (Last) <u>DeLancey</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>7-1-1949</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>12-24-1909</u>		9. AGE (In years last birthday) <u>39</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chiropractor Dr.</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Pensylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William F. DeLancey</u>		13b. MOTHER'S MAIDEN NAME <u>Pearl Aumeller</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Czar DeLancey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mary Czar DeLancey</u> ADDRESS <u>Belmont -306 South</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <u>None.</u>	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Polycystic Renal Disease</u>					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
		19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>7571</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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>June 6, 1949</u> , to <u>July 1, 1949</u> , that I last saw the deceased alive on <u>June 30, 1949</u> , and that death occurred at <u>5:50 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Martin J. Mueller</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>934 Angyle Bldg., K.C. Mo.</u>		23c. DATE SIGNED <u>July 1, 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>7-1-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Altoona</u>		24d. LOCATION (City, town, or county) (State) <u>Altoona, Pensylvania</u>	
DATE REC'D BY LOCAL REG. <u>7-1-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. C.L. Forster</u>		ADDRESS <u>Kansas City, Mo.</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

FEB 23 1960

Chas General Pract
832 79

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Joe B. Yoder

Signed _____

Student Embalmer

Licensed Embalmer No. 4173

P. O. Address K. C. Mo

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.