

FILED JUL 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23717
2985

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

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (in this place) 20 yrs.		d. STREET ADDRESS (If rural, give location) 1617 Euclid	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home 1617 Euclid			

3. NAME OF DECEASED (Type or Print) a. (First) EUGENE b. (Middle) _____ c. (Last) Williams		4. DATE OF DEATH (Month) (Day) (Year) June 20 1950	
5. SEX MALE	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Unknown
9. AGE (In years) IF UNDER 1 YEAR Last birthday 48 Months 2 Days _____ Hours _____ Mins. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UnEmployed	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Unknown	12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Lillie G. Johnson	14. NAME OF MARRIED OR WIFE Bernie Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charles Johnson 1617 Euclid B.5

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 443x
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) hypertensive heart condition		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) none DUE TO (c) none		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none			

19a. DATE OF OPERATION none	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)	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 6/12/1950, to 6/20/1950, that I last saw the deceased alive on 6/18/1950, and that death occurred at 11 P. m., from the causes and on the date stated above.

23a. SIGNATURE E. J. Haugh Jr. M.D.	23b. ADDRESS 2200 East 18th Street	23c. DATE SIGNED 6/29/50
24a. BURIAL/CREMA-TION REMOVAL (Specify) Buried in	24b. DATE 6/18-50	24c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis Mo	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sheraldine Holmes 1st Appleton & Jones City	
DATE REC'D BY LOCAL REG. 7-7-50	REGISTRAR'S SIGNATURE	

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

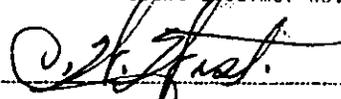
STATEMENT BY LICENSED EMBALMER

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 _____



Signed
Student Embalmer

Licensed Embalmer No. 2710

P. O. Address 15. C. 470

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.