

FILED AUG 21 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27174
Registrar's No. 3327

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 27 yrs		3758	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1514 E. 49th St.		d. STREET ADDRESS (If rural, give location) 1514 E. 49th St.	

3. NAME OF DECEASED (Type or Print) a. (First) ANDREW	b. (Middle) LEO	c. (Last) WILLIAMS	4. DATE OF DEATH (Month) (Day) (Year) Aug. 2, 1950
---	-----------------	--------------------	--

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 18, 1897	9. AGE (in years last birthday) 53	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 MIN. Min.
-------------	------------------------	--	--------------------------------	------------------------------------	------------------------	-----------------------	-----------------------	-----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Indiana	12. CITIZEN OF WHAT COUNTRY? USA
---	-----------------------------------	---	----------------------------------

13a. FATHER'S NAME Harry Williams	13b. MOTHER'S MAIDEN NAME Julia Walker	14. NAME OF HUSBAND OR WIFE Bessie Williams, wife
-----------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 486-05-2193	17. INFORMANT'S SIGNATURE OR NAME KC Mo. ADDRESS Mrs. Bessie Williams, 1514 E. 49th St.,
--	--	--

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 3 hrs 4201
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS, (Specify) _____ 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)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 Aug 2 1950 to Aug 2 1950, that I last saw the deceased alive on Aug 2 1950 and that death occurred at _____, from the causes and on the date stated above.

23a. SIGNATURE I. P. FRICK MD (Degree or title)	23b. ADDRESS 800 Prof. Bldg	23c. DATE SIGNED 8-2-50
---	-----------------------------	-------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-4-50	24c. NAME OF CEMETERY OR CREMATORY Mt Moriah	24d. LOCATION (City, town, or county) (State) K. C. Mo
--	------------------	--	--

DATE REC'D BY LOCAL REG. 8-3-50	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE, Kansas City, Mo.
---------------------------------	--	--

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

Dr. J. Paul Frick
Procy Body
Lv. 1199

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.

Student
Student Embalmer

Signed _____

Max E Meyer

Licensed Embalmer No. _____

P. O. Address _____

4555
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.