

FILED SEP 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30725

3689

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 0</u>		c. LENGTH OF STAY (In this place) <u>63 Years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Trinity Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>3000 Harrison Street 3428</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MAURICE</u>		b. (Middle) <u>T.</u>		c. (Last) <u>WILLIAMS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 28, 1950</u>	
5. SEX <u>Male 0</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 2</u>		8. DATE OF BIRTH <u>Nov. 3, 1866</u>	
9. AGE (In years last birthday) <u>83</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>Retired Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Iowa /</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Morris D. Williams</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Thompson</u>			14. NAME OF HUSBAND OR WIFE <u>Sarah D. Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>493-14-8789</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Sam S. Edwards</u>		ADDRESS <u>K. C. Mo.</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>Coronary Occlusion</u> ANTECEDENT CAUSES <u>Sexility</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>arteriosclerosis.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>420!</u>					INTERVAL BETWEEN ONSET AND DEATH
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) _____		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>July 12, 1950</u> , to <u>Aug 28, 1950</u> , that I last saw the deceased alive on <u>Aug 28, 1950</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Hugh A. Gestring MD</u> (Degree or title)				23b. ADDRESS <u>3031 West 11th Blvd</u>		23c. DATE SIGNED _____	
24a. BURIAL/CREMATION, REMOVAL (Specify) <u>Burial 0</u>		24b. DATE <u>8-30-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>8-29-50</u>		REGISTRAR'S SIGNATURE <u>Seraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Freeman Mortuary</u>		ADDRESS <u>Kansas City, Mo.</u>	

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

W. H. Freeman
1-5

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 _____

J. H. Freeman

Signed.....
Student Embalmer

Licensed Embalmer No. *2939*

P. O. Address *H. C. W. Co.*

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.