

FILED FEB 14 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
360

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>Kansas</u> b. COUNTY <u>Johnson</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>1 Mo.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		<u>8150</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Research Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>5445 Aberdeen</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROY</u>		b. (Middle) <u>ROSS</u>		c. (Last) <u>WILLIAMS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 20 1953</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>2/12/1902</u>	
9. AGE (In years last birthday) <u>50</u>		10. MONTHS <u>50</u>		11. IF UNDER 1 YEAR Days _____		12. IF UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner - Midwest Equipment Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>New Hampton, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13a. FATHER'S NAME <u>Earl Williams</u>		13b. MOTHER'S MAIDEN NAME <u>Mollie B. Maxwell</u>	
14. NAME OF HUSBAND OR WIFE <u>Sadie Ann Williams</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>173-14-5521</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Sadie Ann Williams</u>				18. ADDRESS <u>5445 Aberdeen</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Ventricular fibrillation</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>							
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.							
II. ANTECEDENT CAUSES							
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
DUE TO (b) <u>Hypertension and</u>							
DUE TO (c) <u>Arteriosclerosis and obesity</u>							
III. 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 checked="" 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>Nov 23</u> , 19 <u>49</u> , to <u>Jan 20</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Jan 19</u> , 19 <u>53</u> , and that death occurred at <u>1 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>William F. Sanders</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>1103 Grand KC MO</u>		23c. DATE SIGNED <u>1/20/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1/22/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
DATE REC'D BY LOCAL REG <u>1-20-53</u>		REGISTRAR'S SIGNATURE <u>Deraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>FREEMAN MORTUARY & CHAPEL, K.C., MO.</u>			

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

Dr. Davis, or Dr. Sanders - Prof. Bldg.
1:30 - 4:30 p.m.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.