

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18314**

FILED MAY 21 1953
BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **2299**

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 OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 50 YRS		d. FULL NAME OF HOSPITAL OR INSTITUTION 2800 E 10	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) D c. (Last) Wall		4. DATE OF DEATH (Month) (Day) (Year) 4-28-53	
5. SEX M.	6. COLOR OR RACE Wh.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid. 2	8. DATE OF BIRTH 3-8-1882
9. AGE (In years last birthday) 71		10. KIND OF BUSINESS OR INDUSTRY unemployed	11. BIRTHPLACE (City and State or Foreign Country) Randolph Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME William Hall		13b. MOTHER'S MAIDEN NAME Martha T. Smith	
14. NAME OF HUSBAND OR WIFE Mary Hall Lee		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	
16. SOCIAL SECURITY NO. No.		17. INFORMANT'S SIGNATURE OR NAME Aubrey J Hall Kansas City Mo.	
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) Arteriosclerosis Heart Disease INTERVAL BETWEEN ONSET AND DEATH 42nd 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) Natural	
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) (Min.)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE Hugh H. Owens (Degree or title) Trustee of Queens Cemetery		23b. ADDRESS 1034 Pinta Blvd	
23c. DATE SIGNED 5-2-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 5-6-53		24c. NAME OF CEMETERY OR CREMATORY Shapel Grove	
24d. LOCATION (City, town, or county) (State) Lebanon Mo.		25. FUNERAL DIRECTOR'S SIGNATURE John P. Shul	
DATE REC'D BY LOCAL REG. 5-2-53		REGISTRAR'S SIGNATURE Geraldine Smith	
25. FUNERAL DIRECTOR'S SIGNATURE John P. Shul		ADDRESS K C 40	

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, Student Embalmer No. working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed *John P. Guil*.....

Licensed Embalmer No. *3629*

P. O. Address *T. C. H. D.*

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.