

Health, Welfare and Public Service  
 300-1-56  
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 Ethelene Ray

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

24381 310.4  
 STATE FILE NUMBER 3104

FILED AUG 1 - 1957

Registration District No. 149 Primary Registration District No. 1001 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) <b>VA Hospital</b>			Length of stay in hospital <b>31 years</b>		d. STREET ADDRESS (If outside, give location) <b>7334 Walrond</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM ADAMS</b>				4. DATE OF DEATH <b>July 3, 1957</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-28-1907</b>		9. AGE (In years last birthday) <b>50</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Warehouseman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>A &amp; P Food Stores</b>		11. BIRTHPLACE (City and state or country) <b>Motherwell, Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew Adams</b>				14. MOTHER'S MAIDEN NAME <b>Mary Allan</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>486-07-5130</b>		17. INFORMANT Address <b>VA Hospital Official Records</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary insufficiency.</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Bronchogenic carcinoma</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>162x</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION			CITY	STATE
21. <b>VA</b> attended the deceased from <b>June 3, 1957</b> to <b>July 3, 1957</b> Death occurred at <b>9:50 Pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Ethelene Ray M.D.</b>				22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		22c. DATE SIGNED <b>7-3-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>July-6-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK (Emetoy)</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>			
24. FUNERAL DIRECTOR ADDRESS <b>D. W. NEWCOMER'S SONS, KANSAS CITY, MO.</b>			25. DATE REGD. BY LOCAL REG. <b>7.5.57</b>		26. REGISTRAR'S SIGNATURE <b>Reva Minshel</b>			

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ex-  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Rollie Kessel*.....

Licensed Embalmer No. *46*

P. O. Address *K.C.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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..