

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021774

STATE FILE NUMBER

FILED JUN 24 1959

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2766

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, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen. Hospital		d. STREET ADDRESS 1510 Lydia	

3. NAME OF DECEASED (Type or print) First Middle Last McKinley Williams			4. DATE OF DEATH Month Day Year 6 3 59		
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5. SEX Male	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-18-1896	9. AGE (Years, Months, Days) 62	10. UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Broadway Auction Bureau, Missouri	11. BIRTHPLACE (City and state or country) Burrton, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	13c. NAME OF HUSBAND (USE name) Jella Williams
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	16. SOCIAL SECURITY NO. 494-12-5127	17. INFORMANT Records, C. McGeneral Hospital
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate with Metastasis		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) probably to Spinal Cord		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 177X		

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.) 177X
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20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.	20d. INJURY OCCURRED WHILE AT <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	COUNTY	STATE
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21. I attended the deceased from 5-22-59 to 6-3-59 and last saw ^{him} alive on 6-3-59 Death occurred at 3:05 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) Abraham Gelperin	22b. ADDRESS General Hospital	22c. DATE SIGNED 6-5-59
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23a. BURIAL CREATION, REMOVAL (City, town, or county)	23b. DATE 6-5-1959	23c. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR Wilcox Funeral Homes (W) 2 C Mo	25. DATE RECEIVED LOCAL REG. 6-5-59	26. REGISTRAR'S SIGNATURE Neva Minshall
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(Licensed Emballer's Statement on Reverse Side)

Abraham Gelperin, use only BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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Handwritten notes:
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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 *St. LeRay Mooney*

Licensed Embalmer No. *4776*

P. O. Address *R.O. Mooney*

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.