

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025513

FILED VS JUL 31 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3455 STATE FILE NUMBER

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) Kansas City		Length of stay in lb 15 yrs.	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1213 E. 10th. St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1024 Troost Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Howard Middle Williams Last Williams			4. DATE OF DEATH Month 7 Day 12 Year 59		
5. SEX Male	6. COLOR OR RACE Colored	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-22-1906	9. AGE (last birthday) 53	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Cafe	11. BIRTHPLACE (City and state or country) Sedalia, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Howard Williams		13b. MOTHER'S MAIDEN NAME Mattie		14. NAME OF HUSBAND OR WIFE Gertrude Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 484-05-5889		17. INFORMANT Gertrude Williams, 1024 Troost Address K.C., Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Traumatic Shock.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Sabrahoid Hemorrhage	
DUE TO (c) Fell 25 feet from off of Porch		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) fell from a porch.
20c. TIME OF INJURY Hour 6: p.m. Month, Day, Year 7/12/1959		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1213 E 10th	20f. CITY, TOWN, OR LOCATION Kansas City COUNTY Jackson STATE Mo.
21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE Deputy Coroner		22b. ADDRESS 1618 Lydia Ave		22c. DATE SIGNED 7/14/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 15, 1959	23c. NAME OF CEMETERY OR CREMATORY Forrest Green	23d. LOCATION (City, town, or county) (State) Lexington, Missouri	
24. FUNERAL DIRECTOR Brown-Hudson - K.C., Mo.		25. DATE RECD. BY LOCAL REG. 7-14-59	26. REGISTRAR'S SIGNATURE neva munnhall	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. J. Hillman

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.