

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 21 1959

**59-029379**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3847 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b> Length of stay in 1b <b>30yrs</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital #1</b> Inside Limits <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> c. CITY OR TOWN <b>Kansas City</b> Inside Limits <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>2815 Troost</b> Reside on Farm <input type="checkbox"/> No <input type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>Clarence</b> Middle <b>Williams</b> Last <b>Williams</b>	<b>4. DATE OF DEATH</b> Month <b>8</b> Day <b>6</b> Year <b>59</b>
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<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Sept. 19, 1896</b>	<b>9. AGE (last birthday)</b> <b>62</b>	<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	<b>IF UNDER 24 HR</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>unknown</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Belleville Ill.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b>
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<b>13a. FATHER'S NAME</b> <b>Henry Williams</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Verne Whitmore</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ova Williams</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	<b>16. SOCIAL SECURITY NO.</b> <b>489-22-9111</b>	<b>17. INFORMANT</b> Address <b>Mrs. Ollie Long 2815 Troost</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute and oranzing broncho pneumonia</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH
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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
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
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21. I attended the deceased from 8-3-59 to 8-6-59 and last saw him <sup>XXX</sup> alive on 8-6-59  
 Death occurred at 2:05 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <i>Abraham Gelberlin M.D.</i>	<b>22b. ADDRESS</b> <b>2400 Cherry</b>	<b>22c. DATE SIGNED</b> <b>8-7-59</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>8/8/59</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Forest Hill</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Kansas City Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Stine &amp; McClure K. C. Mo.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>8-8-59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Neva Marshall</i>
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DOCUMENT

BY AFFIDAVIT OF Abraham Gelberlin M.D. MEDICAL CERTIFICATION

**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 Engine L Kenn

Licensed Embalmer No. 463

P. O. Address R. C. 7

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