

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031798

FILED VS. SEP 25 1959

Registration District No. 72 Primary Registration District No. 4134 Registrar's No. 157

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Smithville</u>		Length of stay in 1b <u>40 yrs</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Smithville Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside give location) <u>1516 E 38 St Mo.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Ellen</u> Last <u>Williams</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>14</u> Year <u>59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-04</u>	9. AGE (last birthday) <u>55</u>	# UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Co. Owner Geo. Stone KCK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Peculiar Mo.</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>

13a. FATHER'S NAME <u>Charles Morris</u>		13b. MOTHER'S MAIDEN NAME <u>Matilda Martin</u>		14. NAME OF HUSBAND OR WIFE <u>Otis Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>500-22-2297</u>		17. INFORMANT <u>Mr. Otis Williams of home</u>	

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) <u>Pulmonary embolism,</u>			<u>sudden</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Interstitial carcinoma to lungs</u>		
	DUE TO (c) <u>Carcinoma of ascending colon</u>		<u>3 1/2 yrs</u>
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 type="checkbox"/> NO <input type="checkbox"/>	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 <u>9</u> Month, Day, Year <u>1-59</u> 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 COUNTY STATE

21. I attended the deceased from 8-24-59 to 9-14-59 and last saw her alive on 9-14-59
Death occurred at 3:00 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul Cleaver Jones</u>		22b. ADDRESS <u>Smithville, Mo</u>		22c. DATE SIGNED <u>9-16-59</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 17-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Liberty Clay Mo.</u>
24. FUNERAL DIRECTOR <u>DW Newman Sr</u>		ADDRESS <u>WKP Mo</u>	25. DATE RECD. BY LOCAL REG. <u>9-16-59</u>	26. REGISTRAR'S SIGNATURE <u>Marguerite Ludgens</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DR Paul Lescovo MD
Smithville Hospital

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 John V. Service

Licensed Embalmer No. 9848

P. O. Address K. B. 17

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.