URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 0 1959

59-040470
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5351

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
Length of stay in 1b: 1 Day
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Research Hospital
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Clay
c. CITY OR TOWN: Liberty
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): R. R. # 2 Box 225
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First Everett Middle Last Williams
4. DATE OF DEATH: Month Nov. Day 6 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Feb. 15, 1899
9. AGE (last birthday): 60
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker
10b. KIND OF BUSINESS OR INDUSTRY: New Claco Drive in
11. BIRTHPLACE (City and state or country): Mc Fall Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: Ina Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If Yes, give war or dates of service): W W 1
16. SOCIAL SECURITY NO.: 496-03-0572
17. INFORMANT: Mrs. Ina Williams Address: Liberty Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular collapse
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cardiac standstill
DUE TO (c): vagovagal reflex
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 11-2-59 to 11-6-59 and last saw ~~him~~ him alive on 11-6-59
Death occurred at 12 00 noon m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Robert M. Hazen M.D.
22b. ADDRESS: 600 Angy Bldg K.C. 6, Mo.
22c. DATE SIGNED: 11-6-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11/6/59
23c. NAME OF CEMETERY OR CREMATORY: —
23d. LOCATION (City, town, or county) (State): California Mo.

24. FUNERAL DIRECTOR: Stine & McClure ADDRESS: K.C. Mo.
25. DATE RECD. BY LOCAL REG.: 11-6-59
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Robert M. Hazen

DOCUMENT

VS DEC 1 1959

Will be in office till 5 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Joe B. Yode

Signature of Student Embalmer

Licensed Embalmer No. 417

P. O. Address K. C. M

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