

URTI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040472

FILED VS. DEC 10 1959 149

Primary Registration District No. 1002 Registrar's No.

5740

STATE FILE NUMBER

ENDED

| | | | | | | | | | | |
|---|---|---|--|--|--|--|--|---|--|--|
| 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 | | Length of stay in 1b 6 days | | c. CITY OR TOWN Independence | | Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 11th & Harrison | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 827 So. Woodland | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First WALTER Middle F. Last WILLIAMS | | | | 4. DATE OF DEATH Month November Day 27 Year 1959 | | | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 7-21-1882 | 9. AGE (last birthday) 77 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician | | | 10b. KIND OF BUSINESS OR INDUSTRY Contractor | | 11. BIRTHPLACE (City and state or country) Independence, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | |
| 13a. FATHER'S NAME Alfred Williams | | | 13b. MOTHER'S MAIDEN NAME Elizabeth Mc Daniels | | | 14. NAME OF HUSBAND OR WIFE Nell Williams | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no | | | 16. SOCIAL SECURITY NO. 487-34-0090 | | 17. INFORMANT Address Nell Williams, 827 So. Woodland, Indep. | | | | | |
| 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 Head of Pancreas | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 9-12-59 | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease mentioned in PART I (a) Congruary Artery Disease | | | | | | 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 checked="" 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 _____ a.m. _____ p.m. | | Month, Day, Year | | | | | | | | |
| 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 9-12-59 to 11-27-59 and last saw ^{her} him alive on 11/26/59 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Fred J. Zammar Do | | | | 22b. ADDRESS Indep. Mo | | | | 22c. DATE SIGNED 11/28/59 (State) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 11-30-59 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | | 23d. LOCATION (City, town, or county) Independence, Mo. | | | | |
| 24. FUNERAL DIRECTOR Geo. C. Carson & Sons, Independence, Mo. | | | | 25. DATE RECD. BY LOCAL REG. 11-28-59 | | 26. REGISTRAR'S SIGNATURE Neva Marshall | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Fred J. Zammar

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 Dean M Huff

Licensed Embalmer No. 4914
P. O. Address Indy, Mo.

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.