

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045153

MENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6241 STATE FILE NUMBER

FILED DEC 22 1961

| | | | | | |
|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>JACKSON</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | Length of stay in 1b <u>50 YRS.</u> | c. CITY OR TOWN <u>KANSAS CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARYS HOSPITAL</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>503 EAST 89th ST.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>John A. Williams</u> | | | 4. DATE OF DEATH Month Day Year <u>Dec 8 1961</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</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>MAY 9, 1901</u> | 9. AGE (last birthday) <u>60</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DIV SUPT. TREA.</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRICAL</u> | 11. BIRTHPLACE (City and state or country) <u>STARKVILLE, COLO.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>CARL WILLIAMS</u> | | 13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | 14. NAME OF HUSBAND OR WIFE <u>PAULINE 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 NONE</u> | | | 17. INFORMANT Address <u>PAULINE WILLIAMS 503 EAST 89th ST</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>Plenemia.</u> | | | | | <u>40 hrs</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Nephritis, left kidney</u> | | | | | <u>10 days</u> |
| DUE TO (c) <u>Transitional Cell Carcinoma of bladder 1 yr</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus, Arteriosclerotic Cardio Disease</u> | | | | | 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.) <u>n</u> | | | |
| 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 <u>1977</u> to <u>Dec 8, 1961</u> and last saw him alive on <u>Dec 8, 1961</u> Death occurred at <u>10 A.m</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>John B. Whiteman MD</u> | | | 22b. ADDRESS <u>6914 Brookside Plaza</u> | | 22c. DATE SIGNED <u>12-11-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>12-12-1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. OLIVET Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>Muehlebach</u> | ADDRESS <u>6800 TROOST</u> | 25. DATE RECD. BY LOCAL REG. <u>12-11-61</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u> | | |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
John B. Whiteman

SHOULD READ

Dr. John Whitman
6314 Brookside Plaza
HI 4-6607

12:00 -
per. for 1:00 - 2:00
L. W. S. J. S. P. W.

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 Alfred H. Hammons, Student Embalmer No. 646
working under my personal supervision.

Student Alfred H. Hammons Signed R. E. Nichols
Signature of Student Embalmer

Licensed Embalmer No. 4997
P. O. Address K.C. 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.