

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-036567

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4734 STATE FILE NUMBER

FILED SEP 18 1963

DO NOT WRITE ON THIS STUD AMENDED

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> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>1 week</u>	c. CITY OR TOWN <u>St. Joseph</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>St. Luke's Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1324 Hickory Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>H.</u> Last <u>WILLIAMS</u>			4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1963</u>		
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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>10-1-21</u>	9. AGE (last birthday) <u>41 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freezer Department</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Armour & Co.</u>	11. BIRTHPLACE (City and state or country): <u>Saxton, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>
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13a. FATHER'S NAME <u>John Williams</u>	13b. MOTHER'S MAIDEN NAME <u>Dora Lentz</u>	14. NAME OF HUSBAND OR WIFE <u>Doris Williams</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W. W. # II</u>	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT Address <u>St. Joseph, Mo.</u> <u>Doris Williams - 1324 Hickory St.</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> <u>Intra-ventricular</u> <u>Apoplexy</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u> </u>	DUE TO (c) <u> </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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u> </u>
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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 <u> </u> STATE <u> </u>
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21. I attended the deceased from 10 Aug 63 to death and last saw him alive on death day.
Death occurred at 11:28P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>J. H. Carmichael M.D.</u>	22b. ADDRESS <u>4320 Wernall Rd</u>	22c. DATE SIGNED <u>26 Aug 63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-19-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u> </u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>
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24. FUNERAL DIRECTOR <u>Mellody-McGilley-Eylar Funeral Home</u> <u>Linwood & Woodland</u>	ADDRESS <u> </u>	25. DATE RECD. BY LOCAL REG. <u>8-26-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS-300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF J. A. CARROLL

USE BLACK INK OR TYPEWRITER RIBBON

Francis A. Carmichael Jr.

4320 Warnell Rd.

JE 1-3305

2:40 pm. 8-26-63.

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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 James R. Phillips

Licensed Embalmer No. 4641

P. O. Address K.C. Ma

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.