

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-036569**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5325

DO NOT WRITE ON THIS STUB

AMENDED

**FILED OCT 9 1963**

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>KANSAS CITY</b>		Length of stay in 1b <b>20 yrs.</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>WHEATLY HOSPT.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1326 Michigan</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>WALTER B. WILLIAMS</b>			4. DATE OF DEATH <b>9-27-63</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-6-91</b>	9. AGE (last birthday) <b>71</b>	IF UNDER 1 YEAR Months: Days: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Louisville, Arkansas</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	

13a. FATHER'S NAME <b>Cullen Williams</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Bobbie Williams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Robert T. Williams 1326 Michigan Nephew</b>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertension</b>	
	DUE TO (c)	
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 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: <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>9/26/63 to 9/27/63, and last saw him alive on 9/26/63</b>	COUNTY	STATE
21. I attended the deceased from <b>9/26/63</b> to <b>9/27/63</b> , and last saw him alive on <b>9/26/63</b> . Death occurred at <b>Wheatly Hosp</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>W. Turner</b> (Degree or title)	22b. ADDRESS <b>1612 E 12 Ke. mo.</b>	22c. DATE SIGNED <b>9/30/63</b> (State)
---	--	---

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-1-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Cemetery</b>	23d. LOCATION (City, town, or county) <b>Kansas City, Missouri</b>
24. FUNERAL DIRECTOR <b>Watkins Bros. Funeral Home 18th &amp; Benton</b>		25. DATE RECD. BY LOCAL REG. <b>10-1-63</b>	26. REGISTRAR'S SIGNATURE <b>Debbie Smith</b>

VS 300 Rev. 4/59

1 **23258**

3

4 **2**

5 **1**

6

7 **1**

8 **2**

**94201**

10

11

**127000**

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF **W. Turner**

USE BLACK INK OR TYPEWRITER RIBBON

ORIGINAL  
3532

RECEIVED

RECEIVED

RECEIVED

OFFICE

OFFICE

ADDRESS

ADDRESS

DATE

DATE

TIME

TIME

LOCATION

LOCATION

REMARKS

REMARKS

STATE OF MISSISSIPPI

STATE OF MISSISSIPPI

**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 Bruce R. Watkins

Licensed Embalmer No. 4500

P. O. Address 1020 + Benton

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.

Working Area: Funeral Home 1111 N. Benton