

APR 17 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

9753
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 1002
 (b) Township Raw Primary Registration District No. _____
 (c) City KANSAS CITY, Mo. (d) Street No. St. Lukes Health St. _____
 (If death occurred in Hospital of Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Budge W. Willian
 (a) Residence, No. 112 WEST VALLEY ST. JOSEPH St. St. Joseph, Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Maud Willian
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) FEB. 6 - 1889
 7. AGE YEARS 50 MONTHS 1 DAYS 23 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. INSURANCE AGENT
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAR. 29th 1939
 22. Doc HEREBY CERTIFY, That I attended deceased from 15, 1938, to 3-29, 1939
 I last saw him alive on 3-28, 1939. Death is said to have occurred on the date stated above, at 5:20 AM.
 The principal cause of death and related causes of importance were as follows:
Adenocarcinoma of Lung with metastasis
 Date of onset 47
 Other contributory causes of importance: Metastasis to spine with paralysis.
 Name of operation none Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? yes
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) Duncan C. McQuay, M. D.
 (Address) 1400 City Bldg

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind. 9
 FATHER 13. NAME John Wm. Willian 9
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN 9
 MOTHER 15. MAIDEN NAME MATTIE FOX 9
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN 9
 17. INFORMANT MRS. MAUDE WILLIAN
 (ADDRESS) 112 WEST VALLEY ST. JOSEPH, MO.
 18. BURIAL, CREMATION, OR REMOVAL PLACE St. Joseph, Mo. DATE March 29 1939
 19. FUNERAL DIRECTOR (NAME) FREEMAN & SON INC
 (ADDRESS) 1946 Calhoun St. Joseph Mo.
 20. FILED 3.29 1939 M.M. Crowe Local Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECORD WITH EXPANDING INK—THIS IS A PERMANENT RECORD

1 X18603

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

John E. Rupp

Licensed Embalmer No. *3986*

P. O. Address *St. Joseph*

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 this body is not embalmed, above space should be left blank.