DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5534

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 759

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C.General Hospital No.1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether

In this community: Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 2513 East 9th St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME: FRANCIES WILLIAMSON

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Child

6. (b) Name of husband or wife: --

6. (c) Age of husband or wife if alive: -- years

7. Birth date of deceased: Aug (Month) 21 (Day) 1939 (Year)

8. AGE: Years | Months 25 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace: Kansas City, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation: Child

11. Industry or business:

FATHER
12. Name: Harold Williamson
13. Birthplace: Arkansas (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Myrtle Bell
15. Birthplace: Texas (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Mr. Harold Williamson

(b) Address: 1723 East 9th Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2 (Month) 19 (Day) 40 (Year)

(c) Place: burial or cremation: Greenlawn

18. (a) Signature of funeral director: Weilert Funeral Home

(b) Address: 2332 Monitor Place K. C. Mo.

19. (a) Feb. 19, 1940 (Date received local registrar) (b) M.M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17th year 1940 hour 8 minute 35 A. M.

21. I hereby certify that I attended the deceased from 2-16-40, 19__, to 2-17-40, 19__; that I last saw her alive on 2-17-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchopneumonia Primary	
Due to: 10 yr	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy: See above

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: C. F. De Maria M.D. (M. D. or other)

Address: Supt. K.C.Gen.Hospital 2-17-40 Date signed

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

50M-5-17-39
Rev. 5-17-39
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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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Blaine E. Wilent

Licensed Embalmer No. 4075

P. O. Address 2332 Monitor Place

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.