

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2454

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

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 Mo. & 5 days
(Specify whether
In this community unknown
years, months or days)

3. (a) PRINT FULL NAME John B. Williams 452

8. (b) If veteran, name war unknown 3. (c) Social Security No. unk

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Jan. 21, 1884
(Month) (Day) (Year)

8. AGE: Years 56 Months 4 Days 17 If less than one day hr. _____ min. _____

9. Birthplace Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Auto mechanic

11. Industry or business _____

MOTHER FATHER { 12. Name no record 9
13. Birthplace no record
(City, town, or county) (State or foreign country)
14. Maiden name no record
15. Birthplace no record
(City, town, or county) (State or foreign country)

16. (a) Informant Record Room
(b) Address R.E. Sen. Shop.

17. (a) Burial (b) Date thereof 6-17-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Frank J. Brown

(b) Address Lawson + Main

19. (a) June 16, 1940 (b) M.M. Crowe
(Date received local registrar) (Registrar's signature)

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. 701 1/2 Main St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11th
year 1940 hour 1:00 A.M. minute _____ M. _____

21. I hereby certify that I attended the deceased from May 6th 1940 to June 11th 1940, 19____;

that I last saw him alive on June 11th, 1940, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death post operative co-
lostomy with resection of

Due to Carcinoma of rectosigmoid colon
with metastases to liver

Due to Hb

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy See above

Duration

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Dr. DeWanna M.D. (M. D. or other)
Supt. K.C. Gen. Hospital, K.C. Mo. Date signed _____
Address _____

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.....

Maurice Denis

Licensed Embalmer No. 3634

P. O. Address 90 W Linwood

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.