S. No. 2
—11-10-39
. 5-17-39
P-I X21492

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

FILED AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24234

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 2344

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 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Mo. & 2 days (Specify whether years, months or days) In this community Life

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.: 6439 East 12th St. (If rural, give location)

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

3. (a) PRINT FULL NAME: ALICE WILLIAMS 452

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: Married

6. (b) Name of husband or wife: Olin Williams

6. (c) Age of husband or wife if alive: 35 years

7. Birth date of deceased: October (Month) 8 (Day) 1910 (Year)

8. AGE: Years 29 | Months 9 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace: Camden Point (City, town, or county) Mo (State or foreign country) 6

10. Usual occupation: Housewife 6

11. Industry or business: None

FATHER 12. Name: J. H. Anderson D

13. Birthplace: Woodruff (City, town, or county) Mo (State or foreign country)

MOTHER 14. Maiden name: Lina Lee Bradley

15. Birthplace: Camden Point (City, town, or county) Mo (State or foreign country)

16. (a) Informant: Mrs. Leota Herring

(b) Address: 5811 E 15th Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Camden Point, Mo.

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

(b) Address: 6606 Indep. Ave., K. C. Mo.

19. (a) July 15, 1940 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12th year 1940 hour 2 minute 50 A. M.

21. I hereby certify that I attended the deceased from 6-10-40, 19__, to 7-12-40, 19__; that I last saw her alive on 7-12-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Death incident to Insulin shock therapy; acute congestive heart failure

Due to: with congestion of lungs, liver and spleen

Due to: 1070

Other conditions: Terminal bronchopneumonia (Include pregnancy within 3 months of death)

Major findings: Of operations:

Of autopsy: See above

Duration

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: Barney R. Thomas (M. D. or other)

Address: Med. Dir. K. C. Gen. Hosp. Date signed

(Licensed Embalmer's Statement on Reverse Side)

APR 9 1952

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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

Insulin administered for:

Schizophrenia