No. 2
4-13-40
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X23159

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

FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31038 36912

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

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

(d) Length of stay: In hospital or institution V (Specify whether years, months or days) In this community Unknown

A. C. Williams (N.M.O.)

3. (a) PRINT FULL NAME A. C. Williams

3. (b) If veteran, name war Unk

3. (c) Social Security No. Unk

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Unknown

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
aff 87			hr. min.

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

10. Usual occupation Unknown 9

11. Industry or business " 9

FATHER
12. Name Unknown
13. Birthplace " (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace " (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Negro

(b) Address 345 So Wash Blvd

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/40 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director A Sebbets

(b) Address 901 East 5th St

19. (a) Sept. 15, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 504 Benton (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 9-8-40

year hour minute 3:25 A.M.

21. I hereby certify that I attended the deceased from 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Chronic myocarditis

Due to 93 C

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Inspection

Duration

PHYSICIAN — 93

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 5

23. Signature Victor Whitter (M. D. or other)

Address K. C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Roy E Snow

Licensed Embalmer No. 2570

P. O. Address 1807 E 29

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

If this body is not embalmed, fact should be so stated above.