V. S. No. 2
M—11-10-39
ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 1 ? 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 34514

Registrar's No. 4030

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: Washington Hotel 2 (If not in hospital or institution, write street number or location)

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

In this community 12 years 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")

0 (d) Street No. Washington Hotel (If rural, give location)

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

3. (a) PRINT FULL NAME William A. WILLIAMS

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color race White

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

6. (b) Name of husband or wife Mrs. Cora Jane Williams

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

7. Birth date of deceased January (Month) 29 (Day) 1893 (Year)

8. AGE:

Years	Months	Days	If less than one day
47	8	19	hr. min.

9. Birthplace (City, town, or county) U. S. A. (State or foreign country) 1

10. Usual occupation Barber 9

11. Industry or business

FATHER
12. Name Unknown 9
13. Birthplace (City, town, or county) Unknown (State or foreign country)

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

16. (a) Informant Mr. John Petty

(b) Address Independence, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-40 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director J. F. O'Donnell Company

(b) Address 3256 Broadway, K. C. Mo.

19. (a) 10-20-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day 10-18-40

year hour minute 7 30 A. M.

21. I hereby certify that I attended the deceased from 7 30 A. 19 , to , 19 ; that I last saw Deputy alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Acute toxic hepatitis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 125 B

Major findings:
Of operations

Of autopsy Yes.

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 [signature] (M. D. or other)

Address K. C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

S

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 Park G. Rowe

Licensed Embalmer No. 2347

P. O. Address Ft. C. Mo

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.