

Registration District No. 399

Emergency Registration District No. 1002

Registrar's No. 4464

FILED DEC 1 1940

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of town)
 (c) Name of hospital or institution:
General Hospital #2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9-12-40; 11-17-40
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Edward Williams

3. (b) If veteran, name war _____ 3. (c) Social Security No. no.

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

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

7. Birth date of deceased 12 5 1916
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
23 11 15 hr. _____ min.

9. Birthplace Valley Fall, Kans.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name James Williams

13. Birthplace Valley Fall, Kans.
(City, town, or county) (State or foreign country)

14. Maiden name Bessie Mason

15. Birthplace Independence, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 11-23-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge Mausoleum

18. (a) Signature of funeral director Wm. McCay

(b) Address 1513 Troost

19. (a) 11-23-40 (b) M. J. Crowl
(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. 1400 Garfield
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 17
 year 40 hour 3 minute 05 P. M.

21. I hereby certify that I attended the deceased from 9-12-40
 _____, 19____, to 11-17-40, 19____;
 that I last saw him alive on 11-17-40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Lobar Pneumonia

Due to Dementia Praecox
Paralysis of lt. forearm

Due to _____

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

Major findings: _____
 Of operations _____

Of autopsy _____

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? _____

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

23. Signature J. C. [unclear] (M.D. or other) _____

Address General Hosp. #2 Date signed 11-23-40

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.

108

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.....

L. J. Harris, Sr.

Licensed Embalmer No. 3888

P. O. Address.....

K. 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. *4464*

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

1. PLACE OF DEATH:

(a) County *Jackson*
(b) City or town *K.C.*
(c) Name of hospital or institution: *Gen Hosp 2*
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

3. (a) PRINT FULL NAME *Edward Williams*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *m* 5. Color or race *B* 6. (a) Single, widowed, married, divorced *D*

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

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

8. AGE: Years Months Days If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

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

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) *11/23/40* (b) *m. m. browe*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(d) Street No. _____
(e) If foreign born, how long in U.S.A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month *Nov.* *12* - *40*
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive or _____ and that death occurred on the date and hour stated above.

Immediate cause of death *Lobar Pneumonia* Duration _____

Dementia Praecox

Due to *Paralysis lt. forearm*

Due to *Cerebral Hemorrhage*

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

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

S-37468