

FILED MAR 14 1941
Registration District No. _____

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson
 (a) County Jackson
 (b) City or town Kansas City
 (c) Name of hospital or institution 731 E. 63rd Terrace
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no
 In this community 9 years
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED: 48
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 731 East 63rd Terr.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Mrs. LAURA A WILLIAMS

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

4. Sex F. 5. Color or race W 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Allen D. Williams 6. (c) Age of husband or wife if alive Disced years

7. Birth date of deceased 5 (Month) 21 (Day) 1866 (Year)

8. AGE: Years 74 Months 9 Days 2 If less than one day
 hr. min.

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

10. Usual occupation at home

11. Industry or business none

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Mrs. H. R. Barnes

(b) Address 731 E. 63rd St. Terrace

17. (a) Burial (b) Date thereof 2-25-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation myrtle Mt.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 23
year 1941 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from +
Aug. 1933, to 2-23 1941;
that I last saw her alive on 2-23 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute pulmonary edema Duration 20 min.

Due to Acute insufficiency

Due to Atherosclerosis

Other conditions Cerebral Thrombosis 10 mos.
(Include pregnancy within 3 months of death)

Major findings: 9 1/2"

Of operations 1

Of autopsy 9 2 1/2"

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 0
23. Signature Frank E. Jell (M. D. or other) M.D.
Address 1111 1/2 Park St. Date signed 2-22-41

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 with the above constitutes grounds for revocation of license.)

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