

FILED MAY 16 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **13550**
Registrar's No. **1531**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1531**

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: **3639 1/2 Prospect - 1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **50 yrs**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Kansas City** **3**
(If outside city or town limits, write "RURAL")

(d) Street No. **3639 1/2 - Prospect - 8**
(If rural, give location)

(e) If foreign born, how long in U. S. A. **0** years.

3. (a) PRINT FULL NAME **Alice Sabrina Williams**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Apr** day **14** of **1941** year **1941** hour **4** minute **35** P.M.

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **John Williams**

6. (c) Age of husband or wife if alive **1851** years

7. Birth date of deceased: **Jan 2 - 1851**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Apr 1st** 19**41** to **Apr 14** 19**41** and that death occurred on the date and hour stated above.

8. AGE: Years **90** Months **3** Days **12** If less than one day **hr. min.**

Immediate cause of death **Coronary Myocarditis**

Due to **97 D**

Due to **97 A**

Other conditions (Include pregnancy within 3 months of death)

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

10. Usual occupation **at Home**

11. Industry or business

12. Name **John B. Gilliland**

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

14. Maiden name **Amanda Campbell**

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

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Nellie F. Butler**

(b) Address **2915 - E. 33 St**

17. (a) **Burial** (b) Date thereof **Apr - 16 - 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Haven Cem**

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?

18. (a) Signature of funeral director **Mrs. C. R. Foster**

(b) Address **918 Brooklyn**

19. (a) **Apr 16 1941** (b) **M. Crowe**
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury **0**

23. Signature **Chas. F. Clark** (M. D. or other)

Address **223 W. Apple St. 1909** Date signed

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

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

Gerald J. [Signature]

Licensed Embalmer No.

46522

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, fact should be so stated above.