No. 2
-1-4-41
5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24163

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2702

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: General Hosp. # 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 20 years 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 048

(a) State Mo. (b) County Jackson

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

(d) Street No. 1518 Forest
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Louis Williams

3. (b) If veteran, name war No yes

3. (c) Social Security No. 496-10-4570

4. Sex Male 2

5. Color or race Colored

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

6. (b) Name of husband or wife Winifred Williams

6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased November 18 1896
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
44	7	26	hr. min.

9. Birthplace Lexington MO. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Hod Carrier

11. Industry or business

FATHER
12. Name Harvey Williams
13. Birthplace Lexington, Mo. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Susie
15. Birthplace Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Winifred Williams
(b) Address 1518 Forest

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/41 (Month) (Day) (Year)
(c) Place: burial or cremation Highland.

18. (a) Signature of funeral director Watkins Bros
(b) Address 1729 Lydia Ave.

19. (a) July 18, '41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day 7-14-41
year ..... hour ..... minute ..... M

21. I hereby certify that I attended the deceased from ..... 4:15 P.
..... 19..... to ..... 19.....;
that I last saw him alive on ..... 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration

Subarachnoid cerebral hemorrhage

Fracture of the skull

Injury by fall

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 1860 1864
Of autopsy 39

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) Accident 123
(b) Date of occurrence 7-14-41
(c) Where did injury occur? K. C. (City or town) (County) Mo (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 Arthur W. Mahler (M. D. or other) 35
Address K. C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

AUG 1 1941

SEP 9 1941

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 wit the above constitutes grounds for revocation of license.)

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