

FILED MAY 23 1944

Registration District No.

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Willows Hospital-2929 Main St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 days 5 hrs 15 min.**
(Specify whether
In this community **same**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **2929 Main St**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

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

3. (b) If veteran, name war **---** 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **none**

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

7. Birth date of deceased **May 2 1944**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 5 hr. 15 min.

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

10. Usual occupation **none**

11. Industry or business

12. Name **---**

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

14. Maiden name **Millicent Williams**

15. Birthplace **St Croix Falls Wisconsin**
(City, town, or county) (State or foreign country)

16. (a) Informant **A.U. Dysart R.N.**

(b) Address **2929 Main St**

17. (a) **Burial** (b) Date thereof **May 8th 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greenlawn Cemetery**

18. (a) Signature of funeral director **Eylar Funeral Home**

(b) Address **1800 Linwood**

19. (a) **5-8-44** (b) **N.E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **4** th
year **1944** hour **7:30** minute **A.M.**

21. I hereby certify that I attended the deceased from **May 2**, 19 **44** to **May 4**, 19 **44**;

that I last saw him alive on **May 4**, 19 **44** and that death occurred on the date and hour stated above.

Immediate cause of death **prematurity**

Due to **unknown**

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **none**

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?

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

23. Signature **H.L. Dwyer** (M. D. or other)

Address **315 Alameda Rd** Date signed **5-4-44**

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 ^{not} ~~was~~ embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Chas. C. Wilks

Licensed Embalmer No. ~~7800~~ 2644

P. O. Address *1900 Linwood*

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.