

UNITED STATES HEALTH DEPARTMENT
STANDARD CERTIFICATE OF DEATH

33497

State File No.

4172

FILED OCT 29 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

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

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:
823 East 71st. Terrace
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 35 Yrs years, months or days)

3. (a) PRINT FULL NAME Charles A. Williams

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male 0

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Sept 7 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>1</u>	<u>8</u>	hr. _____ min.

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

10. Usual occupation Retired Dactative

11. Industry or business _____

12. Name John A. Williams

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

14. Maiden name Nancy Baxter

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

16. (a) Informant Arley Williams

(b) Address 823 East 71 St Terrace

17. (a) Burial (b) Date thereof Oct. 17 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Slater Mo.

18. (a) Signature of funeral director Mrs C. L. Forster

(b) Address 918 Brooklyn

19. (a) 10-16-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 823 East 71 St Terrace 7
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15
year 1944 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on Deputy Coroner, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Broncho pneumonia
Coronary Arteriosclerosis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) 94 a

Major findings:
Of operations _____

Of autopsy Inspection History

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)

Means of injury _____

23. Signature A. E. Washer (M. D. or other) 0 MD
T. E. Brown Date stated 10/16/44

MOTHER FATHER

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.....

J. P. Herrick

Licensed Embalmer No. *3599*.....

P. O. Address *H. 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.