

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 4 1944

Registration District No. **1002** Primary Registration District No. **1002**

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:
2301 E 38th
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 58 years
years, months or days

3. (a) PRINT FULL NAME MARY ANN WILLIAMS

3. (b) If veteran, name war none

3. (c) Social Security No. none

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

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

6. (b) Name of husband or wife Merle Williams **6. (c) Age of husband or wife if alive** 60 years

7. Birth date of deceased July 10 1887
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>57</u>	<u>4</u>	<u>5</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Thomas Wedderburn

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

14. Maiden name Marquette Sullivan

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

16. (a) Informant Merle Williams (husb)

(b) Address 2301 E 38

17. (a) Burial, cremation, or removal Burial **(b) Date thereof** Nov 18 44
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Marys

18. (a) Signature of funeral director J. E. Brown

(b) Address 2657 Sway Ln

19. (a) 11-17-44 **(b) J. E. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City 47
(If outside city or town limits, write "RURAL") 2

(d) Street No. 2301 E 38
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 15
year 1944 hour 8 P.M. minute 50 P.M.

21. I hereby certify that I attended the deceased from Feb 16 1943 to date 11-15 1944
that I last saw h. or alive on 7-15 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Ulcercardial Failure (Degeneration) **Duration** 18 yrs

Due to Heart Disease, Essential and Toxic Ulcerative Degeneration

Due to Chronic Pericarditis in Childhood
Relapsed Tuberculosis in adulthood

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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 Horace E. Williams (M. D. or other) 0

Address 618 Professional Bldg **Date signed** 11/17/44

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 F. S. Walton

Licensed Embalmer No. 2744

P. O. Address. 3030 Harrison

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.

Mantz