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y. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40424

State File No. _____

FILED JAN 4 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5185

1. PLACE OF DEATH: Jackson

(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: 708 West 48th Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 43 years
(Specify whether years, months or days)

In this community: 43 years

3. (a) PRINT FULL NAME: Roberta Marshall Williams

3. (b) If veteran, name war: None

3. (c) Social Security No: 492-14-5531

4. Sex: Female

5. Color or race: Col

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

6. (b) Name of husband or wife: George Williams

6. (c) Age of husband or wife if alive: 48 years

7. Birth date of deceased: August 8, 1901
(Month) (Day) (Year)

8. AGE: Years 43, Months 4, Days 6, If less than one day hr. min.

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

10. Usual occupation: Maid

11. Industry or business: Hotel

MOTHER FATHER { 12. Name: Moses Dayton

13. Birthplace: Clay County, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name: Amanda Walker

15. Birthplace: Henry County, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant: George Williams

(b) Address: 708 West 48th St.

17. (a) burial (b) Date thereof: 12/19/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Highland Cemetery

18. (a) Signature of funeral director: *Atkins Bros*

(b) Address: 1729 Lydia

19. (a) 12-20-44 (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.: 708 West 48th St. 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 11
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December, Day 14th, Year 1944, hour 8:45, minute P. M.

21. I hereby certify that I attended the deceased from Oct 22, 1944 to December 14, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Apoplexy

Due to: Arterio sclerosis 2 yrs

Due to: Arterial hypertension 3 yrs

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

Major findings: Of operations: 83a

Of autopsy:

Duration: 2 3/4 hrs

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: *W. H. Keller* (M. D. or other) *MD*

Address: 1701 Jackson Date signed: 12/11/44

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

Dr. Keifer, 1701 Prospect.

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 with the above constitutes grounds for revocation of license.)

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