

12-45  
5-17-39  
PI X47070

State File No. 37242  
Registrar's No. 4778

FILED NOV 25 1946

Registration District No. 149 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:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME James E. Williams

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 18 1929  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

17 8 25 1/4 hr. min.

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

10. Usual occupation None

11. Industry or business X

MOTHER FATHER { 12. Name Harry W. Williams

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

14. Maiden name Violet Evans

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

16. (a) Informant Mrs. Pearl Williams

(b) Address Clinton, Missouri

17. (a) Burial (b) Date thereof Nov. 14, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clinton, Missouri

18. (a) Signature of funeral director Consalus & Peck

(b) Address Clinton, Missouri

19. (a) 11-13-46 (b) Sheraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry 420

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 12  
year 1946 hour 3 minute A. M.

21. I hereby certify that I attended the deceased from Nov. 5, 1946 to Nov. 12, 1946;  
that I last saw him alive on Nov. 12, 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor-Bronchopneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: See Above

Of operations \_\_\_\_\_

Of autopsy See Above

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in:

(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 Wm W Hart (M. D. or other) MD  
Address Med. Dir. Gen'l Hosp Date signed 11-12-46

MAR 25 1947

*Heckman*

**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 *Chas E Wilks* .....

Licensed Embalmer No. *2644* .....

P. O. Address *H. C. Gno* .....

**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.**

FILED FEB 24 1947/49

Registration District No. ....

Primary Registration District No. 1002

Registrar's No. 4778

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: Gen. Hosp. #1  
(If not in hospital or institution, write street number & location)  
(d) Length of stay: In hospital or institution. (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME James E. Williams

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

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

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 11-13-46 (Date received local registrar) (b) Thalaine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 12 Year 1946 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: acute hemorrhagic encephalitis

Due to \_\_\_\_\_  
Due to broncho pneumonia

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death) 107

Major findings: Of operations \_\_\_\_\_

Of autopsy see above

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 Wm W. Hart (M. D. or other) \_\_\_\_\_

Address Gen. Hosp #1 Date signed 11-12-46

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

SUPPLEMENTARY

37242