

No. 2
-12-45
-5-17-39
I X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40920
Registrar's No. 5421

FILED JAN 7 1947
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:
10 East 32nd St terr
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 37 years (Specify whether years, months or days)

In this community _____

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

3. (b) If veteran, name war No

3. (c) Social Security No. 515-16-0890

4. Sex Male 0 5. Color or race white

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

6. (b) Name of husband or wife Mrs Viola Williams

6. (c) Age of husband or wife if alive 60 yrs years

7. Birth date of deceased Feb 19 1888
(Month) (Day) (Year)

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

58 10 0 hr. min.

9. Birthplace Vandalia Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Pharmist

11. Industry or business Manager of Drug Store

MOTHER FATHER { 12. Name Uria Williams

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

14. Maiden name Emma Leslie

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

16. (a) Informant Mrs Viola Williams

(b) Address 10 East 32nd terr

17. (a) burial (b) Date thereof 12-26-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Calvary Cemetery

18. (a) Signature of funeral director Wm H. Smith
20 West Linwood

(b) Address _____

19. (a) 12-26-46 (b) Steraldine Holmes
(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
(If outside city or town limits, write "RURAL")

(d) Street No. 10 East 32nd St. Terr
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 19th
year 1946 hour 5-03 minute _____ M.

21. I hereby certify that I attended the deceased from 12-9-46
~~12-10-46~~ 12-19 to 12-19 1946
that I last saw him alive on 12-18 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration _____

Due to Chronic Myocarditis

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____ 93 d

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. Smith (M. D. or other) _____
Address 532 Commercial R.C.H. Date signed 12-26-46

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 Howard W. Farmer

Licensed Embalmer No. 4134

P. O. Address Honore City, 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.