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13731

DEPARTMENT OF COMMERCE

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 12 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1985

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 1 mo. 7 days
(Specify whether
 In this community 40 years
years, months or days)

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. 1218 W. 23 St. 8
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country

3. (a) PRINT FULL NAME Ira Williams
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 1
 year 1947 hour 6 minute 5 P. M.
 21. I hereby certify that I attended the deceased from
March 25 1947 to May 1 1947
 that I last saw her alive on May 1 1947
 and that death occurred on the date and hour stated above.

4. Sex Female / 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Charles Calvin Williams
 6. (c) Age of husband or wife if alive 72 years
 7. Birth date of deceased May 21 1881
(Month) (Day) (Year)

Immediate cause of death.....
Pulmonary embolism
 Due to.....
 Due to Post operative repair of umbilical hernia
 Other conditions.....
(Include pregnancy within 3 months of death)
 Major findings: 122a
 Of operations.....
 Of autopsy see above

8. AGE: Years Months Days If less than one day
65 11 10 hr. min.
 9. Birthplace Missouri (C)
(City, town, or county) (State or foreign country)
 10. Usual occupation House Wife

PHYSICIAN
 Underline the cause to which death should be charged statistically.
 See above

11. Industry or business.....
 12. Name W.M. Renfrow
 13. Birthplace No record 9
(City, town, or county) (State or foreign country)
 14. Maiden name Gullner
 15. Birthplace No record 9
(City, town, or county) (State or foreign country)
 16. (a) Informant Charles Calvin Williams
 (b) Address 1218 West 23 St.
 17. (a) Burial (b) Date thereof May 5 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt Washington Cem.
 18. (a) Signature of funeral director Mrs. C. L. Forster
 (b) Address 918 Brooklyn
 19. (a) 5-3-47 (b) Stalding Holmes
(Date received local registrar) (Registrar's signature)

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 pluse) (e) Means of injury
 23. Signatures W. W. Hardy (M. D. or other) Med
 Address Med. Dir. Gen'l Hosp. Date signed 5-2-47

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

MOTHER FATHER

Dr. H. H. H.

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..... *Corland Muior*.....

Licensed Embalmer No..... *3414*.....

P. O. Address..... *918 Broadway*.....

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.