

FILED JAN 20 1948
 Registration District No. **249**

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. 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **14 DAYS**
(Specify whether years, months or days)
 In this community **14 days**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MISSOURI** (b) County **JACKSON**
 (c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
 (d) Street No. **718 CAMPBELL**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **INFANT WILLIAMS**
 3. (b) If veteran, name war **NO**
 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **DECEMBER** day **27**, year **1947** hour **10**: minute **25** P.M.

4. Sex **MALE**
 5. Color or race **NEGRO**
 6. (a) Single, widowed, married, divorced **SINGLE**
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

21. I hereby certify that I attended the deceased from **DECEMBER 13, 1947** to **DECEMBER 27, 1947**; that I last saw him **IM** alive on **DECEMBER 27, 1947**; and that death occurred on the date and hour stated above.

7. Birth date of deceased **DECEMBER 13, 1947**
(Month) (Day) (Year)
 8. AGE: Years Months Days If less than one day
14 hr. min.

Immediate cause of death **EXTREME MALNUTRITION**
 Duration _____

9. Birthplace **KANSAS CITY MISSOURI**
(City, town, or county) (State or foreign country)
 10. Usual occupation **NONE**

Due to _____
 Due to _____
 Other conditions (includes pregnancy within 3 months of death) **158**

11. Industry or business _____
 12. Name **FARMER WILLIAMS**
 13. Birthplace **KANSAS CITY MISSOURI**
(City, town, or county) (State or foreign country)
 14. Maiden name **ROWENA JONES**
 15. Birthplace **INDEPENDENCE MISSOURI**
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
 Of autopsy **SAME AS ABOVE**
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant **ROWENA WILLIAMS (MOTHER)**
 (b) Address **718 CAMPBELL**
 17. (a) **Burial** (b) Date thereof **1-22-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

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? _____

18. (a) Signature of funeral director **Wm. G. Schreyer**
 (b) Address **City Mortician**
 19. (a) **12-31-47** (b) **Sheldine Holmes**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (e) _____ (Specify type of injury)
 23. Signature **YONAS** (M. D. or other) **M.D.**
 Address **GENERAL HOSPITAL NO. 2** Date signed **12/30/47**

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.....

Not Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed.....*Wm A. Schuyler*.....

Licensed Embalmer No. *3089*.....

P. O. Address.....*15C MD*.....

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.