

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 16 hrs.  
(Specify whether  
 In this community About 18 years  
years, months or days)

**3. (a) PRINT FULL NAME** David Williams  
 3. (b) If veteran, name war None  
 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 \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Unknown 1868  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>?</u>	<u>?</u>	hr. _____ min. _____

9. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Pensioner

11. Industry or business \_\_\_\_\_  
 12. Name Unknown 9  
 13. Birthplace Unknown 1  
(City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown 7  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk  
 (b) Address K.C. General Hosp. #1

17. (a) Anatomical (b) Date thereof 6-4-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Western Dental College

18. (a) Signature of funeral director Weilert Funeral Home  
 (b) Address 2332 Monitor Place: K. C. Mo.

19. (a) 6-4-48 (b) Geraldine Adams  
(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") 8  
 (d) Street No. 54 1/2 MAIN  
(If rural, give location) 8  
 (e) Citizen of foreign country? Unknown (Yes or No) 0  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 28  
 year 1948 hour 3 minute 52 A.M.

21. I hereby certify that I attended the deceased from May 27, 1948, to May 28, 1948  
 that I last saw him alive on May 28, 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Carcinoma of lung

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) 472

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy None

**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  
 Signature W. W. Hart (M. D. or other) MD  
 Address Med. Dir. Gen'l Hosp. Date signed 5-28-48

*D. Coleman*

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**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 \_\_\_\_\_

*Blaine E. Wickett*

\_\_\_\_\_  
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.**