

FILED AUG 23 1948

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **862**

1. PLACE OF DEATH:

(a) County **Buchanan**
 (b) City or town **St. Joseph**
 (c) Name of hospital or institution: **State Hospital no 2**
 (d) Length of stay: In hospital or institution **4 mo 4 days**
 In this community **4 mo 4 days**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Clay**
 (c) City or town **Yashland**
 (d) Street No. **Rural**
 (e) Citizen of foreign country? **no**

3. (a) PRINT FULL NAME **John Amos Williams**

3. (b) If veteran, name war: **----** 3. (c) Social Security No. **----**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced, **widowed**
 6. (b) Name of husband or wife **not known** 6. (c) Age of husband or wife if alive **9** years
 7. Birth date of deceased **Nov 9, 1861**

8. AGE: Years **1 86-** Months **9** Days **3** If less than one day **hr. min.**

9. Birthplace **Platte Co Mo**

10. Usual occupation **Farmer**

11. Industry or business **Retired**

MOTHER FATHER { 12. Name **unknown**
 13. Birthplace **no record**
 14. Maiden name **unknown**
 15. Birthplace **no record**

16. (a) Informant **Mrs. Esther Kumer**

(b) Address **Yashland MO**

17. (a) **Removal** (b) Date thereof **8-12-48**

(c) Place: burial or cremation **Kansas City MO**

18. (a) Signature of funeral director **Mrs. C. J. Foster**

(b) Address **Kansas City Missouri**

19. (a) **Aug 16, 1948** (b) **E. C. Jenkins**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **12** year **1948** hour **12** minute **20** A. M.

21. I hereby certify that I attended the deceased from **April 8, 1948** to **Aug 12, 1948** that I last saw him alive on **Aug 11, 1948** and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**

Due to **Arteriosclerosis**

Due to **---**

Other conditions (Include pregnancy within 3 months of death) **---**

Major findings: Of operations **---** Of autopsy **---**

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 **James Thomas** (M. D. or R. N.)

Address **St. Joseph MO** Date signed **8/12/48**

Duration **---**
 PHYSICIAN **---**
 Underline the cause to which death should be charged statistically.

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

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..... *Joe B. Yoder*
Licensed Embalmer No..... *4173*
P. O. Address..... *918 Broadway*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

KC. Mo