

FILED APR 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8690
State File No. 1218

BIRTH MO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (In this place) about 2 1/2 yrs		d. STREET ADDRESS (If rural, give location) 1204 Woodland	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1126 Woodland			

3. NAME OF DECEASED (Type or Print) a. (First) Powell	b. (Middle) Clayton	c. (Last) Williams	4. DATE OF DEATH (Month) (Day) (Year) Mar. 10, 1949
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Aug. 20, 1886	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 62	IF UNDER 24 HRS. Hours 62	Min. 62
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ft. Smith, Ark. /	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John C. Williams	13b. MOTHER'S MAIDEN NAME Amanda Harris	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs. Josephine Perry-	ADDRESS 1100 Paseo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Sudden Death			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION See Relatives in Post Mortem	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) natural	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4201
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Hugh H. Owens	(Degree or title) Coroner	23b. ADDRESS 1034 East Olds	23c. DATE SIGNED 3-10-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/16/49	24c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, MO.
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DATE REC'D BY LOCAL REG. 3-16-49	REGISTRAR'S SIGNATURE Stoddard Holmes	25. FUNERAL DIRECTOR'S SIGNATURE E. Sterling Bells	ADDRESS 1212 Vine
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WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

E. Sterling Bills

Signed _____

Student Embalmer

Licensed Embalmer No. 3178

P. O. Address 212 Vine St., Kansas

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.