

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1429**
REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **30**

FILED JAN 21 1950

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

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 OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. LENGTH OF STAY (in this place) 15 YEARS		d. STREET ADDRESS (If rural, give location) 9 EAST-32ND STREET TERRACE	
d. FULL NAME OF HOSPITAL OR INSTITUTION 32ND STREET TERRACE MAIN DAUG STORF			

3. NAME OF DECEASED (Type or Print) Schuyler. Graves Williams	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) JAN. 3-1950
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 28-1915	9. AGE (In years last birthday) 34 YEARS	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDANT-ASSEMBLY LINE - VENDO COMPANY	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) JOPLIN, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME OSWALD WILLIAMS	13b. MOTHER'S MAIDEN NAME EDITH TAPLOCK	14. NAME OF HUSBAND OR WIFE MRS. JERENE ISABEL WILLIAMS
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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. 487-05-7131	17. INFORMANT'S SIGNATURE OR NAME Mrs. JERENE ISABEL WILLIAMS	ADDRESS 9 EAST-32ND STREET KANSAS CITY, MO.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory failure - Acute Polycystic Kidney Disease - B. lateral		INTERVAL BETWEEN ONSET AND DEATH
	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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Deputy Coroner	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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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 **6:30A** m., from the causes and on the date stated above.

23a. SIGNATURE A. E. Upsher (Degree or title) MD	23b. ADDRESS 2800 Main	23c. DATE SIGNED 1/3/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JAN 4-1950	24c. NAME OF CEMETERY OR CREMATORY City Cemetery	24d. LOCATION (City, town, or county) (State) St. Clairton, PA
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DATE REC'D BY LOCAL REG. 1-4-50	REGISTRAR'S SIGNATURE Thelma Holmes	25. FUNERAL DIRECTOR'S SIGNATURE W. Newcomer	ADDRESS 1331-34th CREEK KANSAS CITY, MO.
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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.....

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working under my personal supervision.

Student Embalmer No.....

Signed Edmund M. Storey

Signed.....

Student Embalmer

Licensed Embalmer No. 4452

P. O. Address K.C. 14 Mo.

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.