

FILED MAR 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9099

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1094

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (In this place) <u>10 yrs.</u>		d. STREET ADDRESS (If rural, give location) <u>215 Indep. Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>215 Indep. Ave.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Carl</u> b. (Middle) _____ c. (Last) <u>Williams</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>3-1-50</u>		
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5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Apr. 12, 1867</u>		9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months Days		IF UNDER 14 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pensioner</u>				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) <u>Illinois</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			

13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Unknown</u>		
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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) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Inez Mays</u>		ADDRESS <u>Same</u>	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Asteroic Schistocytosis</u>						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 <u>4000</u>						20. AUTOPSY? YES <input 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)	
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?	

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 5 p. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Geo. C. Kealhofer</u> (Degree or title)		23b. ADDRESS <u>Kansas City, Mo.</u>		23c. DATE SIGNED <u>3-2-50</u>	
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24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-2-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Kan.</u>	
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DATE REC'D BY LOCAL REG. <u>3-8-50</u>		REGISTRAR'S SIGNATURE <u>Heraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B. E. Weelert</u>		ADDRESS <u>K. C. Mo.</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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.

Student
Student Embalmer

Signed _____

Blaine E. Weelitz

Licensed Embalmer No. _____

4075

P. O. Address _____

L.C. & Co.

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.