

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **28941**
4169
Registrar's No. _____

FILED SEP 11 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY <u>Jackson</u>		a. STATE <u>Missouri</u>	b. COUNTY <u>Cass</u>
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	c. LENGTH OF STAY (in this place) <u>41 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Drexel</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Trinity Lutheran Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>0190 1</u>	

3. NAME OF DECEASED			4. DATE OF DEATH		
a. (First) <u>Lillie</u>	b. (Middle) <u>(none)</u>	c. (Last) <u>Williams</u>	(Month) <u>August</u>	(Day) <u>21</u>	(Year) <u>53</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>May 11, 1871</u>		9. AGE (In years) <u>82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Coshocton, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>Robert E. Karr</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Holloway</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas Williams</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records</u> ADDRESS <u>Kansas City, Mo</u>

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 <u>2 days</u> <u>5 months</u> <u>15 1/2</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchopneumonia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cancer of stomach.</u> 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>Unoperable carcinoma of unknown origin</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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) 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 7-16 1953, to 8-21, 1953, that I last saw the deceased alive on 8-21, 1953, and that death occurred at 8:05 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Geraldine A. van der Veen</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Trinity Lutheran Hosp.</u>	23c. DATE SIGNED <u>8-21-53</u>
24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-23-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Glenwild Cemetery</u>
24d. LOCATION (City, town, or county) (State) <u>Westline, Cass, Mo.</u>		

DATE REC'D BY LOCAL REG. <u>8-24-53</u>	REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ward B. Runyan</u> ADDRESS <u>Louisburg Kansas</u>
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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.....

.....
working under my personal supervision.

Student Embalmer No.

Signed.....

Walter B. Ruyter

Signed.....
Student Embalmer

Licensed Embalmer No. *3222*

P. O. Address *Louisburg Kansas*

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.