

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

16254

State File No. _____

FILED JUN 3 1954

No. 300
10.48

BIRTH NO. _____		REG. DIST. NO. <u>149</u>	PRIMARY REG. DIST. NO. <u>1002</u>	Registrar's No. <u>2228</u>
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. LENGTH OF STAY (in this place) <u>1190</u>	c. CITY OR TOWN <u>KANSAS CITY</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST MARYS HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>718-LINWOOD AVE</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>MILEY</u> b. (Middle) <u>HAWKINS</u> c. (Last) <u>WILLIAMS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 14 1954</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 8-1881</u>	9. AGE (In years last birthday) <u>72</u> UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>GEORGE WILLIAMS</u>		13b. MOTHER'S MAIDEN NAME <u>MARY M. HAWKINS</u>	14. NAME OF HUSBAND OR WIFE <u>NETTIE KINSEY WILLIAMS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>495-24-5236</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Max Carl Crosby</u> ADDRESS <u>3720 Wyndott</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Colon</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>with widespread metastases</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		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 <u>5/10</u> , 19 <u>54</u> , to <u>5/15</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>54</u> , and that death occurred at <u>12:25</u> P m., from the causes and on the date stated above.				
23a. SIGNATURE <u>Mary C. Colglazier</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>5100 East 24th</u>	23c. DATE SIGNED <u>5/15/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>MAY 12, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>LAKE SIDE CEMETARY</u>	24d. LOCATION (City, town, or county) (State) <u>TINA MO</u>	
DATE REC'D BY LOCAL REG. <u>5-17-54</u>	REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Shiel</u> ADDRESS <u>Ho. C. Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Mary Colglower
5106 - 8 - 34th
Re 8818.

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.....
Signature of Student Embalmer

Signed *Richard E. Carroll*

Licensed Embalmer No. *481*

P. O. Address *R. E. Carroll*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.