

FILED AUG 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27220
Registrar's No. 3275

BIRTH NO. 920 2187-54 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

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) OR TOWN Kansas City		c. CITY OR TOWN 41 Kansas City	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 2406 Tracy		e. STREET ADDRESS (If rural, give location) 2406 Tracy	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Duncan c. (Last) Jr.			4. DATE OF DEATH (Month) (Day) (Year) July 11, 1954		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Jan. 24, 1954	9. AGE (In years last birthday) if UNDER 1 YEAR Months Days if UNDER 10 HOURS Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <input type="checkbox"/> Kansas City, Missouri	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME William Duncan		13b. MOTHER'S MAIDEN NAME Louise Randall		14. NAME OF HUSBAND OR WIFE None	
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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. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Duncan 2406 Tracy	
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 59 1/2
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Glomerular Nephritis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic adhesive Pleurisy		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	

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 _____, 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 <i>[Signature]</i>		23b. ADDRESS M. D. 1618 Lydia Ave		23c. DATE SIGNED 7/13/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/17/54		24c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery	
24d. LOCATION (City, town, or county) Kansas City, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Geraldine Smith Westlawn Cem. 18th & Benton			
DATE REC'D BY LOCAL REG. 7-13-54		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Geraldine Smith Westlawn Cem. 18th & Benton			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
L. M. Tillman MD

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..... *Bruce R. Washburn*

Licensed Embalmer No. *45*

P. O. Address *18th St. S.*

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.