

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34226**

FILED NOV 10 1954

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4894

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)		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 General Hospital #2		STREET ADDRESS (If rural, give location) 1705 Lydia	
3. NAME OF DECEASED (Type or Print) John		4. DATE OF DEATH (Month) (Day) (Year) 10 14 1954	
a. (First) John		b. (Middle) J	
c. (Last) Williams			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 8-29-88
9. AGE (In years) 66	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours Mln.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) supervisor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Cincinnati Ohio	12. CITIZEN OF WHAT COUNTRY? U. S.
13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Road office RC Ben ADDRESS K.C. Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Anoxia		DUE TO (b) Cerebral vascular accident.		4250
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Arteriosclerotic heart disease.		
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		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) 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 10-8-54, 19 , to 10-14-54, 19 , that I last saw the deceased alive on 10-14-54, 19 , and that death occurred at 5:45 am., from the causes and on the date stated above.

23a. SIGNATURE E. Frank Ellis (Degree or title)	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 10-14-54
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 10-20-54	24c. NAME OF CEMETERY OR CREMATORY St. Louis
24d. LOCATION (City, town, or county) (State) St. Louis Mo		25. FUNERAL DIRECTOR'S SIGNATURE Wm. Lohmeyer ADDRESS City Mo
DATE REC'D BY LOCAL REG. 10-21-54	REGISTRAR'S SIGNATURE neva minshall	

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.....
Signature of Student Embalmer

Signed..... *Blaine E. Hele*

Licensed Embalmer No. *407*

P. O. Address *NC 7*

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.