

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34227**

FILED OCT 20 1954

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4583

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 town) Kansas City c. LENGTH OF STAY (In this place) 37 yrs
c. CITY OR TOWN Kansas City d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION 2636 Brooklyn STREET ADDRESS (If rural, give location) 2636 Brooklyn

3. NAME OF DECEASED (Type or Print)
a. (First) Dr. John b. (Middle) Robert c. (Last) Williams, Sr. 4. DATE OF DEATH (Month) (Day) (Year) Sept. 28, 1954

5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 8. DATE OF BIRTH Jan. 5, 1887 9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 1 Hrs. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) Hampton, Virginia 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Rev. John Chambers Williams 13b. MOTHER'S MAIDEN NAME Rhodie Jane Sinclair 14. NAME OF HUSBAND OR WIFE Esther Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT'S SIGNATURE OR NAME Esther Williams ADDRESS 2636 Brooklyn

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerephageal Hemorrhage (Vain)
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES DUE TO (b) Portal hypertension
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
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 _____ 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 5-21-54, to 9-28-54, that I last saw the deceased alive on 9-28-54, and that death occurred at 4:10 p., from the causes and on the date stated above.

23a. SIGNATURE Royall B. Fleming, MD (Degree or title) 23b. ADDRESS 1433 E-19th St. N. City 23c. DATE SIGNED 9-30-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 10-2-54 24c. NAME OF CEMETERY OR CREMATORY Memphis, Tenn 24d. LOCATION (City, town, or county) (State) Memphis, Tenn.

DATE REC'D BY LOCAL REG. 9-30-54 REGISTRAR'S SIGNATURE Neva Marshall 25. FUNERAL DIRECTOR'S SIGNATURE Walter's Bros. Funeral Home ADDRESS 18th & Benton

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Royall B. Fleming

Dr Fleming

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 P. Watkins*.....

Licensed Embalmer No. *450*.....

P. O. Address *18th Street*.....

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.