

FILED JAN 5 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41311**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **5766**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Kansas City</b>		c. LENGTH OF STAY (In this place) <b>70 yrs</b>	c. CITY OR TOWN <b>Kansas City</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>583 Harrison</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
STREET ADDRESS (If rural, give location) <b>583 Harrison</b>		<b>3038</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) <b>Henry</b>	b. (Middle) <b>Thomas</b>	c. (Last) <b>Williams</b>	<b>Dec. 14, 1954</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Aug. 20, 1908</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 1 HR. <b>46</b> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>construction</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Clair, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Henry Williams</b>	13b. MOTHER'S MAIDEN NAME <b>Myra Patterson</b>	14. NAME OF HUSBAND OR WIFE <b>Hazel Williams</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>384-10-3075</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Hazel Williams</b>	ADDRESS <b>583 Harrison</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>Provisional</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Cardiac Hypertrophy Co.</b>		
*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		<b>Edema</b>
	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Right Heart Failure</b> DUE TO (c) <b>Acute Bilateral Pulmonary</b>		
II. OTHER SIGNIFICANT CONDITIONS		<b>4343</b>	
Conditions contributing to the death but not related to the disease or condition causing death. <b>Aortic Regurgitation</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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 \_\_\_\_\_, 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 (Name or Title) <b>L. M. Tillman</b>	23b. ADDRESS <b>1618 Lydia Ave</b>	23c. DATE SIGNED <b>12/15/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Dec. 18, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lincoln</b>	24d. LOCATION (City, town, or county) (State) <b>Kansas City Mo.</b>
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DATE REC'D BY LOCAL REG. <b>12-16-54</b>	REGISTRAR'S SIGNATURE <b>Neve Marshall</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Watkins Bros. Funeral Home</b>	ADDRESS <b>1800 Benton</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
L. M. Tillman

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. Watkins*

Licensed Embalmer No. *4500*

P. O. Address *18<sup>th</sup> 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.