

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27214

STATE FILE NUMBER

FILED AUG 29 1956

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 366

300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |                                  |   |  |  |  |  |  |   |                          |  |
|---|----------------------------------|---|--|--|--|--|--|---|--------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |  |  |  |   |                          |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Independence</b>  |                                  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>         | c. CITY OR TOWN<br><b>Independence</b>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |   |                          |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br><b>Sanitarium</b>  |                                  |   | Length of stay in lb<br><b>6 days</b>  | d. STREET ADDRESS<br><b>913 W. Hayward</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>           |  |   |                          |  |
| 3. NAME OF DECEASED (Type or print)<br><b>James Villers</b>   |                                  |   |  | First  | Middle   | Last   | 4. DATE OF DEATH<br><b>Aug. 18, 1956</b>   |   |                          |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar. 24, 1924</b>   |  | 9. AGE (In years last birthday)<br><b>32</b>                           | IF UNDER 1 YEAR<br>Months  | IF UNDER 24 HRS.<br>Days                   | IF UNDER 24 HRS.<br>Hours   | IF UNDER 24 HRS.<br>Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Muller Operator</b>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Furnace foundry</b>                                  |  | 11. BIRTHPLACE (City and state or country)<br><b>Lexington, Mo.</b>    |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |   |                          |  |
| 13. FATHER'S NAME<br><b>Heber Villers</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Hazel E. Fry</b>  |  |  |  |   |                          |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>513 14 2086</b>   |  | 17. INFORMANT<br><b>Mrs. Mildred K. Villers, Independence Mo</b>   |  |  | Address                                    |   |                          |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b>  |                                  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |                          |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |                                  | DUE TO (b) <b>Arteriolonephrosclerosis (malignant hypertension)</b>   |  |  |  |  |  |   |                          |  |
| DUE TO (c)  |                                  |   |  |  |  |  |  |   |                          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                          |  |
| 20a. ACCIDENT <input type="checkbox"/>  | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/>   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |  |  |   |                          |  |
| 20c. TIME OF INJURY<br>Hour, Month, Day, Year<br>a. m.<br>p. m.   |                                  |   | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)    |  |  |  |  |   |                          |  |
| 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 20f. CITY, TOWN, OR LOCATION   |  | COUNTY   |  | STATE   |                          |  |
| 21. I attended the deceased from <b>Aug 13 1956</b> to <b>Aug 18 1956</b> and last saw her/him alive on <b>Aug 18 1956</b> .<br>Death occurred at <b>7:20A</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |  |  |  |  |  |   |                          |  |
| 22a. SIGNATURE (Degree or title)<br><b>Harold V Woods M.D.</b>  |                                  |   |  | 22b. ADDRESS<br><b>Independence Mo</b>   |  |  | 22c. DATE SIGNED<br><b>Aug 20 56</b>       |   |                          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE<br><b>8/22/56</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>McPahle Cemetery</b>                                |  | 23d. LOCATION (City, town, or county) (State)<br><b>Lexington, Mo.</b> |  |  |   |                          |  |
| 24. FUNERAL DIRECTOR<br><b>H. B. Carson</b>   |                                  |   |  | ADDRESS<br><b>Independence, Mo.</b>  |  | 25. DATE RECD. BY LOCAL REG.<br><b>8-20-56</b>                                       |  | 26. REGISTRAR'S SIGNATURE<br><b>James Kray</b>  |                          |  |

(Licensed Embalmer's Statement on Reverse Side)

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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 *Harold E. Noadref*

Licensed Embalmer No... *46*

P. O. Address *Indep. 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.