

FILED DEC 11 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
40672  
5509

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

S. 300  
ev. 1-57

|  |                               |   |   |
|--|-------------------------------|---|---|
| 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>OR<br>TOWN <b>Kansas City</b>   |                               | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>Kansas City</b><br>208   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Research Hosp.</b>   |                               | Length of stay in lb<br><b>45 Yrs.</b>  | d. STREET ADDRESS <b>5818 E. 12th</b> (If outside, give location)<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JAMES</b> Middle <b>C.</b> Last <b>WILLS</b>   |                               |   | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>19,</b> Year <b>1957</b>   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <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 <b>2-17-1883</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dentist</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) <b>74</b><br>IF UNDER 1 YEAR: Months Days<br>IF UNDER 24 HRS.: Hours Min.                                       |
| 13a. FATHER'S NAME<br><b>James C? Wills</b>  |                               | 13b. MOTHER'S MAIDEN NAME<br><b>Isabel Mc Kenzie</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</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>487-44-0820</b>   | 14. NAME OF HUSBAND OR WIFE<br><b>Mrs. Grace Wills</b>  |
| 17. INFORMANT<br><b>Mrs. Grace Wills</b> Address <b>K. C. Mo.</b>  |                               |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 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>Emphysema Both Lungs</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Extreme Fibrosis Rt. Lft Lung Ten years</b><br>DUE TO (c) <b>Extensive Kidney Thrombosis 5-25 Ten years</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Extreme Fibrosis Both at Left Lung</b> |                               |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Unknown</b>  |
| 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. p.m.  |                               | 20d. INJURY OCCURRED 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<br>COUNTY STATE  |   |
| 21. I attended the deceased from <b>December 8, 1941</b> to <b>Nov 19, 1955</b> and last saw <sup>him</sup> alive on <b>Nov 19, 1957</b> .<br>Death occurred at <b>12:45 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                               |   |   |
| 22a. SIGNATURE<br><b>Harold A. Pallett, M.D.</b> (Degree or title)   |                               | 22b. ADDRESS<br><b>1132 Prof. Bldg. K.C. Mo.</b>  |   |
| 22c. DATE SIGNED<br><b>11/20/57</b>  |                               | 23a. BURIAL, CREMATION, REBURYAL (Specify)<br><b>Burial</b>   |   |
| 23b. DATE<br><b>11-22-57</b>   |                               | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Hill</b>  |   |
| 23d. LOCATION (City, town, or county)<br><b>Kansas City, Mo.</b> (State)   |                               | 24. FUNERAL DIRECTOR<br><b>Freeman Mortuary</b> ADDRESS <b>K. C. Mo.</b>  |   |
| 25. DATE RECD. BY LOCAL REG.<br><b>11-21-57</b>  |                               | 26. REGISTRAR'S SIGNATURE<br><b>Ilova Marshall</b>  |   |

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Harold A. Pallett use ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



*W. Harold V. ...  
132 Prof. ...  
2-5*

**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 *J. P. Freeman* .....

Licensed Embalmer No. 2939

P. O. Address F. O. Mo.

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.