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FILED FEB 24 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-005953 STATE FILE NUMBER 568

Registration District No. 149 Primary Registration District No. 1001 Registrar's No.

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): KANSAS City — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): RESEARCH Hospital — Length of stay in Ib: 53 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JACKSON
c. CITY OR TOWN: KANSAS City — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 510 WABASH AVENUE — Reside on Farm: Yes [ ] No [X]

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3. NAME OF DECEASED (Type or print): First: JOHN Middle: M. Last: WILLIAMS

4. DATE OF DEATH Month Day Year: JANUARY 31 1958

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Oct 30, 1882

9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): ELEVATOR OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY: RESEARCH HOSP.

11. BIRTHPLACE (City and state or country): COLUMBUS, WISCONSIN

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: GRIFFITH Williams

13b. MOTHER'S MAIDEN NAME: CATHERINE GRIFFITH

14. NAME OF HUSBAND OR WIFE: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 494-14-3174A

17. INFORMANT: DORA WILLIAMS Address: 510 WABASH. K.C. MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c): 4201

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? YES [X] NO [ ]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 Jan. 14, 1958, to Jan. 31, 1958 and last saw him alive on Jan. 31, 1958
Death occurred at 3:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): M.D.

22b. ADDRESS: 924 Professional Bldg.

22c. DATE SIGNED: 2/1/58

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: FEB. 3, 1958

23c. NAME OF CEMETERY OR ~~CREMATORY~~: GRIDLEY CEMETERY

23d. LOCATION (City, town, or county) (State): GRIDLEY KANSAS

24. FUNERAL DIRECTOR ADDRESS: D.W. NEWCOMER'S SONS. 1331 BRUSH CREEK KANSAS City. Mo.

25. DATE RECD. BY LOCAL REG.: 2-3-58

26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Don A. Black

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 Vern Fowler

Licensed Embalmer No. 4915

P. O. Address K.C. 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.