

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-005956  
STATE FILE NUMBER 762

FILED MAR 3 - 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
-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 TOWN <b>Kansas City</b>   |                                   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  | c. CITY OR TOWN <b>Kansas City</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |                                |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>817 Jefferson</b>   |                                   |   | Length of stay in lb<br><b>24</b> years  |  | d. STREET ADDRESS (If outside, give location)<br><b>817 Jefferson</b>     |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |                                |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>MR. JOHN A. WILLIS</b>   |                                   |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Feb. 11, 1958</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>Dec. 22, 1892</b>   |   | 9. AGE (In years last birthday)<br><b>65</b>   | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Flour Mill</b>                                       |  | 11. BIRTHPLACE (City and state or country)<br><b>Minnesota</b>            |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                |  |
| 13a. FATHER'S NAME<br><b>John Willis</b>  |                                   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Alice Jennison</b>   |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Shalah Willis</b>                                  |   |                                |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes or unknown) (If yes, give date of service)<br><b>Yes W. W. #1</b>  |                                   |   | 16. SOCIAL SECURITY NO.<br><b>682-67-1210</b>  |  | 17. INFORMANT<br>Address<br><b>Shalah Willis 817 Jefferson, Apt. #710</b> |  |   |                                |  |
| 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>Acute Coronary Thrombosis</b>   |                                   |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>  |                                |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |                                   | DUE TO (b) <b>Arteriosclerotic Heart Disease</b>  |  |  |   |  | 4 yr  |                                |  |
|   |                                   | DUE TO (c)  |  |  |   |  | 42-50   |                                |  |
| 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 type="checkbox"/> NO <input checked="" 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. 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   |   | COUNTY   |   | STATE                          |  |
| 21. I attended the deceased from <b>1954</b> , to <b>Feb 11 1958</b> and last saw him alive on <b>Feb. 1 1958</b><br>Death occurred at <b>10:30</b> <b>A</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>Ann Robinson M.D.</b>  |                                   |   |  | 22b. ADDRESS<br><b>4635 W. Yonahdale</b>   |   | 22c. DATE SIGNED<br><b>2-12-58</b>   |   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   | 23b. DATE<br><b>Feb. 14, 1958</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>D. W. Newcomer's</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City, Missouri</b>  |   |  |   |                                |  |
| 24. FUNERAL DIRECTOR<br><b>Sine &amp; McClure Und. Co. K. C., Mo</b>  |                                   |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>2-12-58</b>   |   | 26. REGISTRAR'S SIGNATURE<br><b>Neva Minshall</b>                                    |   |                                |  |

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
A. W. Robinson

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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 *Elmer D. Tipton* .....

Licensed Embalmer No. *4817*.....

P. O. Address *Kansas City, 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.