

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-010278

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1030

300  
-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1705 E. 17th Ter.</u>			Length of stay in lb <u>26 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>1705 E. 17th Terr.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Hayden</u> Middle <u>Taylor</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 3, 1887</u>		9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Barber shop</u>		11. BIRTHPLACE (City and state or country) <u>Otterville, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Peter Williams</u>				13b. MOTHER'S MAIDEN NAME <u>Patsy Lacey</u>		14. NAME OF HUSBAND OR WIFE <u>Lorraine Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>495-09-5406</u>		17. INFORMANT Address <u>Mrs. Lorraine Williams, 1705 E. 17th T</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 9/160</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c) <u>Carbon monoxide Gas Poison</u>					
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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT <input checked="" 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.) <u>House Fire</u>						
20c. TIME OF INJURY Hour <u>10:30</u> Month <u>2</u> Day <u>21</u> Year <u>1958</u> a.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>1705 E 17th terrace</u>						
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>			COUNTY <u>Jackson</u>		STATE <u>Mo</u>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Deputy Coroner</u>				22b. ADDRESS <u>1618 Lydia Ave</u>				22c. DATE SIGNED <u>2/21/58</u>	
23a. BURIAL (CREMATION, REMOVAL (Specify)) <u>Removal</u>		23b. DATE <u>2/27/58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crown Point cemetery Linwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>			
24. FUNERAL DIRECTOR <u>Badeau, Appleton &amp; Jones, K.C., Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>2-25-58</u>		26. REGISTRAR'S SIGNATURE <u>reva minshall</u>			

L. M. Tillman USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Conrado Adalberto Bales* .....

Licensed Embalmer No. *4944* .....  
P. O. Address *K.S. Ho* .....

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.