

Health,
& Welfare
Public
Service

FILED MAY 2 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014537
STATE FILE NUMBER
1896

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1896

300
1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City,
c. FULL NAME (If outside corporate limits, give location) HOSPITAL OR INSTITUTION Walnut Nursing Home		Length of stay in lb- 83 yrs	d. STREET ADDRESS (If outside, give location) 514 East 9th Street
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last JAMES A. WILLIAMS			4. DATE OF DEATH Month Day Year April 12 1958		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 1969 88	9. AGE (In years last birthday)	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Manager Clothing Store		10b. KIND OF BUSINESS OR INDUSTRY Sage Goods	11. BIRTHPLACE (City and state or country) Peoria, Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Isabelle Hutchinson	14. NAME OF HUSBAND OR WIFE Mary Williams
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 720	17. INFORMANT Address Mrs. Jessie Williams, 7226 Charlotte
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis, Generalized	5 years.
	DUE TO (c) Senility and General Deterioration	331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Previous Cerebral Hemorrhage and Paralysis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year 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
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21. I attended the deceased from 1 Jan 57 to 12 April 58 and last saw ^{him} alive on 6 April 58 . Death occurred at 12:30 am on the date stated above; and to the best of my knowledge, from the causes stated.		
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22a. SIGNATURE (Degree or title) Wallace H. Graham M.D.	22b. ADDRESS 578 Argyle Bldg.	22c. DATE SIGNED 12 April 58.
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-14-58	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar Funeral Home	25. DATE RECD. BY LOCAL REG. 4-12-58	26. REGISTRAR'S SIGNATURE neva Marshall
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24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar Funeral Home		25. DATE RECD. BY LOCAL REG. 4-12-58	26. REGISTRAR'S SIGNATURE neva Marshall
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24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar Funeral Home		25. DATE RECD. BY LOCAL REG. 4-12-58	26. REGISTRAR'S SIGNATURE neva Marshall
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Woodland-Linwood K.E. Mo. (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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Wallace H. Graham

*Dr. Wallace Smith
angels Bldg.
Rm 1-0111*

12-6 PM



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 *John A. Hedmon*

Licensed Embalmer No. *5025*

P. O. Address *Indep, 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.