

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014539
STATE FILE NUMBER

FILED MAY 9 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1767

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 type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 610 N. Wabash		Length of stay in lb 59 yrs.	d. STREET ADDRESS (If outside, give location) 610 N. Wabash Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Simon Middle Menter Last Williams			4. DATE OF DEATH Month April Day 4 Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1883
9. AGE (In years last birthday) 74		IF UNDER 1 YEAR Months Days	IF UNDER 24 MRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Public Works Dept.	11. BIRTHPLACE (City and state or country) Ray County, Mo.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Menter Williams	
13b. MOTHER'S MAIDEN NAME unk.		14. NAME OF HUSBAND OR WIFE Minnie May Williams	
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. 500-12-7789	17. INFORMANT Mrs. Minnie Williams Address 610 N. Wabash
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma to Spinal Cord DUE TO (b) Prostatic Carcinoma DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma, metastases to brain & lungs			INTERVAL BETWEEN ONSET AND DEATH 8 wks 177X
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Hour _____ a.m. Month, Day, Year _____ p.m.		20d. INJURY OCCURRED WHILE AT <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 Kansas City Jackson Mo	
21. I attended the deceased from March 1, 1958 to April 4, 1958 and last saw him/her alive on April 4, 1958 Death occurred at 5:50A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE K. L. Shireman, M.D. (Degree or title)		22b. ADDRESS 4606 St. John K. C. Mo.	22c. DATE SIGNED 4-4-58
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 4-7-58	23c. NAME OF CEMETERY OR CREMATORY Forest Hill	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR Sheil Funeral Home, K. C. Mo. ADDRESS		25. DATE RECD. BY LOCAL REG. 4-5-58	26. REGISTRAR'S SIGNATURE neva minshall

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
K. L. Shireman

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 *Thomas A. Steel*

Licensed Embalmer No. *4954*

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.