

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029318

STATE FILE NUMBER

3900

FILED AUG 27 1958

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

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 OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3604 Bellaire		Length of stay in 1b 7 yrs.	d. STREET ADDRESS (If outside, give location) 3604 Bellaire
3. NAME OF DECEASED (Type or print) First FANNIE Middle WILLIAMS Last WILLIAMS		4. DATE OF DEATH Month August Day 10, Year 1958	
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 45 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) Durant, Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Dennice Rice		13b. MOTHER'S MAIDEN NAME Sarah Harrington	14. NAME OF HUSBAND OR WIFE Cleo 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. 414-34-0586	17. INFORMANT Cleo Williams 3604 Bellaire Husband
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cardio-Reno-Vascular Disease DUE TO (c) Arteriosclerosis 4427			INTERVAL BETWEEN ONSET AND DEATH
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 Hour . Month, Day, Year a.m. 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
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Deputy Coroner		22b. ADDRESS 1618 Lydia Ave	22c. DATE SIGNED 8/13/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-16-58	23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Watkins Bros. Funeral Home 18th & Benton		25. DATE RECD. BY LOCAL REG. 8-13-58	26. REGISTRAR'S SIGNATURE Neva Minshall

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

L. M. Tillman

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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 *Bruce R. Watkins*

Licensed Embalmer No. *4500*

P. O. Address *18th & Bent*

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.