

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036699
STATE FILE NUMBER
4855

FILED OCT 29 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

S. 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		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA Queen of the World 20 yrs.		d. STREET ADDRESS (If outside, give location) 4041 Agnes	

3. NAME OF DECEASED (Type or print) First Middle Last HERSCHEL RAYMOND WILLIAMS			4. DATE OF DEATH Month Day Year October 9, 1958		
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIAGE NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1916	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY FEED Ralston-Purina Co.	11. BIRTHPLACE (City and state or country) Speed, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Hearndon Williams	13b. MOTHER'S MAIDEN NAME Mattie Baskett	14. NAME OF HUSBAND OR WIFE Dorothy Williams
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWII	16. SOCIAL SECURITY NO. 490-16-4331	17. INFORMANT Dorothy Williams	Address 4041 Agnes
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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) <u>Bronchial Asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
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 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.)
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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 KC Jackson COUNTY STATE
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21. I attended the deceased from death occurred at <u>his residence</u> on <u>10/9/58</u> and last saw him alive on <u>9/25/58</u>	
22a. SIGNATURE <u>W. Turner</u> (Degree or title)	22b. ADDRESS 1612 E 12th KC Mo

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-14-58	23c. NAME OF CEMETERY OR CREMATORY National	23d. LOCATION (City, town, or county) (State) Leavenworth, Kans.
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24. FUNERAL DIRECTOR Watkins Bros. Funeral Home 18th - Benton	25. DATE RECD. BY LOCAL REG. 10-14-58	26. REGISTRAR'S SIGNATURE Neva Minshall
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

L. W. Turner

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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 & 2nd*

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.