

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-040266

STATE FILE NUMBER 5144

FILED NOV 19 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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) Kansas City		Inside Limits Yes <input 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 St. Marys Hosp		Length of stay in lb 35 yrs		d. STREET ADDRESS (If outside, give location) 2914 Flora	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM WASHINGTON			4. DATE OF DEATH Month Day Year Oct. 29, 1958		
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1882	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY R.I. RR. Co.		11. BIRTHPLACE (City and state or country) Gillam, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Thornton Washington		13b. MOTHER'S MAIDEN NAME Sarah Bell Piper	
14. NAME OF HUSBAND OR WIFE Irene Washington		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. 708-10-8402	
17. INFORMANT Irene Washington		Address 2914 Flora		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and Atherosclerotic Heart Disease DUE TO (b) Chronic Glomerular Nephritis DUE TO (c) Acute Cystitis and Pyelitis	
INTERVAL BETWEEN ONSET AND DEATH 5 yrs		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)		20c. TIME OF INJURY Hour a.m. p.m. 6:30 a.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION Kans		20f. COUNTY Kans		20g. STATE Kans	
21. I attended the deceased from Jan. 1956 to Oct. 29, 1958 and last saw him alive on 10-28-58 Death occurred at 6:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE L. F. Steffen M.D.		22b. ADDRESS 1103 Grand Ave City Mo	
22c. DATE SIGNED 10-30-58		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-1-58	
23c. NAME OF CEMETERY OR CREMATORY Westlawn Cem.		23d. LOCATION (City, town, or county) Kansas City, Kans.		23e. STATE Kans.	
24. FUNERAL DIRECTOR Nathan W. Thatcher		ADDRESS K.C.K.		25. DATE RECD. BY LOCAL REG. 10-30-58	
26. REGISTRAR'S SIGNATURE neva Marshall					

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *Cleypod J Woods*

Licensed Embalmer No. *3106*

P. O. Address *1520 N. 5th*

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.