THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-047177 ✓
STATE FILE NUMBER

FILED JAN 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6192

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN: KANSAS CITY, MO — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: GENERAL HOSPITAL — Length of stay in 1b: 4 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JACKSON
c. CITY OR TOWN: KANSAS CITY, MO — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 3317 E 19th — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First STELLA Middle Last WILLIAMS

4. DATE OF DEATH: Month 12 Day — Year 28-58

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 4-26-77

9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): pensioner

10b. KIND OF BUSINESS OR INDUSTRY: XX

11. BIRTHPLACE (City and state or country): Holt County, Mo.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: JAMES McCLASKEY

13b. MOTHER'S MAIDEN NAME: SARAH BARNARD

14. NAME OF HUSBAND OR WIFE: Chas. J. Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO XX

16. SOCIAL SECURITY NO.: None

17. INFORMANT: GENERAL HOSPITAL Address: K.C.MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): POSSIBLE PULMONARY EMBOLUS — INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerotic heart disease — 1 day
DUE TO (c): & calcific aorta stenosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4 2 ND'

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ] 2

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 12-28-58, to 12-28-58 and last saw her him alive on 12-28-58
Death occurred at 11:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Abraham Gelperin M.D.

22b. ADDRESS: GENER AL HOSPTTAL

22c. DATE SIGNED: 12-29-58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 12-29-58

23c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery

23d. LOCATION (City, town, or county) (State): Mound City, Mo.

24. FUNERAL DIRECTOR ADDRESS: Wagner Funeral Home K C Mo

25. DATE RECD. BY LOCAL REG.: 12-29-58

26. REGISTRAR'S SIGNATURE: Vera Minshall

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-57 O

Abraham Gelperin M.D. Use BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.