Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001574

STATE FILE NUMBER 129

FILED JAN 21 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Kansas City — Inside Limits Yes XX No
c. FULL NAME OF HOSPITAL OR INSTITUTION 4001 Warwick Blvd. Plaza Nursing Home — Length of stay in 1b 15 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes XX No
d. STREET ADDRESS (If outside, give location) 8225 Belleview — Reside on Farm Yes No XX

3. NAME OF DECEASED (Type or print) First MISS Middle MARGARET Last WILLIAMSON

4. DATE OF DEATH Month January Day 7 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED NEVER MARRIED XX WIDOWED DIVORCED
8. DATE OF BIRTH Aug. 22, 1872
9. AGE (In years last birthday) 86 — 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) School Teacher
10b. KIND OF BUSINESS OR INDUSTRY Education
11. BIRTHPLACE (City and state or country) Union City, Tennessee
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME J. A. Williamson
13b. MOTHER'S MAIDEN NAME Sophia Goss
14. NAME OF HUSBAND OR WIFE --

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Plaza Nursing Home - 4001 Warwick Boyd.

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) Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH 4 da
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Jaundice Cause undetermined — 10 da
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 491X
19. WAS AUTOPSY PERFORMED? YES NO X

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 Oct 25, 1958 to Jan 6, 1958 and last saw her alive on Jan 6, 1959
Death occurred at on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Orval T. Needels (Degree or title) MD
22b. ADDRESS 7400 Wornall KC Mo
22c. DATE SIGNED Jan 9, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 1/9/59
23c. NAME OF CEMETERY OR CREMATORY Mt Washington
23d. LOCATION (City, town, or county) Kansas City (State) Mo.

24. FUNERAL DIRECTOR Stine & McClure Und. Co., K.C., Missouri
ADDRESS
25. DATE RECD. BY LOCAL REG. 1-8-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

Orval T. Needels USE ONLY 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 .....
Signature of Student Embalmer

Signed William M. Turner

Licensed Embalmer No. 4648

P. O. Address Kansas City, 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.