

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013621

STATE FILE NUMBER

2064

FILED MAY 13 1959

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

Health,  
Welfare  
Public  
Service

100  
-57

|                                                                                                                                                                                                                                    |  |                                                                                                                |                                                                                                             |                                                                                                                                                             |                                                                                  |                                                                                                   |                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>                                                                                                                                                                                      |  |                                                                                                                |                                                                                                             | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>                  |                                                                                  |                                                                                                   |                                                                                       |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Kansas City</u>                                                                                                                                            |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                           |                                                                                                             | c. CITY OR TOWN <u>308 Kansas City</u>                                                                                                                      |                                                                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |                                                                                       |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Gen. Hospital</u>                                                                                                                                |  |                                                                                                                | Length of stay in lb<br><u>65 yrs.</u>                                                                      |                                                                                                                                                             | d. STREET ADDRESS (If outside, give location)<br><u>2322 Summit</u>              |                                                                                                   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>ES</u> Middle <u>CHARLES</u> Last <u>CALVIN WILLIAMS</u>                                                                                                                           |  |                                                                                                                |                                                                                                             | 4. DATE OF DEATH<br>Month <u>4</u> Day <u>23</u> Year <u>59</u>                                                                                             |                                                                                  |                                                                                                   |                                                                                       |  |
| 5. SEX <u>Male</u>                                                                                                                                                                                                                 |  | 6. COLOR OR RACE <u>White</u>                                                                                  |                                                                                                             | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                                                                  | 8. DATE OF BIRTH<br><u>10-7-1874</u>                                                              |                                                                                       |  |
| 9. AGE (In years last birthday) <u>84</u>                                                                                                                                                                                          |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Carpenter</u> |                                                                                                             | 11. BIRTHPLACE (City and state or country)<br><u>Dresden, Missouri</u>                                                                                      |                                                                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                     |                                                                                       |  |
| 13a. FATHER'S NAME<br><u>George W. Williams</u>                                                                                                                                                                                    |  |                                                                                                                | 13b. MOTHER'S MAIDEN NAME<br><u>Harriet Davis</u>                                                           |                                                                                                                                                             |                                                                                  | 14. NAME OF HUSBAND OR WIFE<br><u>Ira Williams</u>                                                |                                                                                       |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                |  |                                                                                                                | 16. SOCIAL SECURITY NO.<br><u>496-07-6957</u>                                                               |                                                                                                                                                             | 17. INFORMANT Address<br><u>Mrs. Gloria J. McGuffin; 2701 W. 40th. K.C., Mo.</u> |                                                                                                   |                                                                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>                                                                            |  |                                                                                                                |                                                                                                             |                                                                                                                                                             |                                                                                  | INTERVAL BETWEEN ONSET AND DEATH                                                                  |                                                                                       |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____<br>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?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                                                                       |  |
| 20a. ACCIDENT - SUICIDE - HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>                                                                                                                   |  |                                                                                                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br><u>491X</u> |                                                                                                                                                             |                                                                                  |                                                                                                   |                                                                                       |  |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.                                                                                                                                                                                  |  |                                                                                                                |                                                                                                             |                                                                                                                                                             |                                                                                  |                                                                                                   |                                                                                       |  |
| 20d. INJURY OCCURRED WHILE AT WORK <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 <u>4-4-59</u> to <u>4-23-59</u> and last saw him alive on <u>4-23-59</u><br>Death occurred at <u>2:00 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |                                                                                                                |                                                                                                             |                                                                                                                                                             |                                                                                  |                                                                                                   |                                                                                       |  |
| 22a. SIGNATURE (Degree or title)<br><u>Abraham Gelpin</u>                                                                                                                                                                          |  |                                                                                                                | 22b. ADDRESS<br><u>Gen. Hospital</u>                                                                        |                                                                                                                                                             | 22c. DATE SIGNED<br><u>4-23-59</u>                                               |                                                                                                   |                                                                                       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                         |  | 23b. DATE<br><u>4-25-1959</u>                                                                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mount Washington</u>                                               |                                                                                                                                                             | 23d. LOCATION (City, town, or county) (State)<br><u>Kansas City, Missouri</u>    |                                                                                                   |                                                                                       |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Weilert Funeral Homes; K.C., Mo. (S)</u>                                                                                                                                                        |  |                                                                                                                |                                                                                                             | 25. DATE RECD. BY LOCAL REG.<br><u>4-24-59</u>                                                                                                              |                                                                                  | 26. REGISTRAR'S SIGNATURE<br><u>Neal Marshall</u>                                                 |                                                                                       |  |

All diseases in Part I must be causally related.

Abraham Gelpin, M.D., USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *B. E. Weir*

Licensed Embalmer No. *4075*

P. O. Address *K.C. 8, 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.