

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013624

STATE FILE NUMBER
1589

FILED APR 20 1959 Registration District No. 149 Primary Registration District No. 1000 Registrar's No.

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| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Kansas City</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gen. Hospital</u> | | Length of stay in 1b <u>35 YRS</u> | d. STREET ADDRESS (If outside, give location) <u>423 S Cypress</u> |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>H</u> Last <u>WILLIAMS</u> | | | 4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>59</u> | | | |
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| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar 10, 1891</u> | 9. AGE (In years last birthday) <u>67</u> | 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) <u>Retired Electrician</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Sheffield Steel</u> | 11. BIRTHPLACE (City and state or country) <u>Kennwood, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>Ab. S. A.</u> |
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| 13a. FATHER'S NAME <u>William H. Williams</u> | 13b. MOTHER'S MAIDEN NAME — | 14. NAME OF HUSBAND OR WIFE <u>Mellie Helena Williams</u> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u> | 16. SOCIAL SECURITY NO. — | 17. INFORMANT <u>William H. Williams Jr. - K.C. Mo.</u> | Address — |
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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>myocardial infarction</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Arterio-sclerotic coronary thrombosis</u> | |
| | DUE TO (c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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. _____ 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 | COUNTY | STATE |
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| 21. I attended the deceased from <u>3-18-59</u> to <u>3-26-59</u> and last saw ^{her} _{him} alive on <u>3-26-59</u> Death occurred at <u>2:35 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>Abraham Galperin</u> (Degree or title) <u>0</u> | 22b. ADDRESS <u>Gen. Hospital</u> | 22c. DATE SIGNED <u>3-26-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Mar 29, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Sheil Funeral Home</u> | ADDRESS <u>K.C. Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>3-27-59</u> | 26. REGISTRAR'S SIGNATURE <u>Neve Winshall</u> |
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.
 MEDICAL CERTIFICATION
 Abraham Galperin M. D.

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

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.