

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018026  
STATE FILE NUMBER 2465

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH (If deceased lived. If institution: Residence before admission)  
a. COUNTY Jackson  
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits  
Kansas City Yes  No   
c. CITY OR TOWN Kansas City  
d. STREET ADDRESS (If outside, give location) Reside on Farm  
2905 Forest Yes  No

3. NAME OF DECEASED First Middle Last  
Mattie Agnes Williams  
4. DATE OF DEATH Month Day Year  
5 17 59  
5. SEX 3 6. COLOR OR RACE 7. MARRIED  NEVER MARRIED   
Female Negro WIDOWED  3 DIVORCED   
8. DATE OF BIRTH 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.  
Unknown About 75 Months Days Hours Min.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY Unknown 11. BIRTHPLACE (City and state or country) 12. CITIZEN OF WHAT COUNTRY?  
Unknown South Carolina 1 U.S.A.

13a. FATHER'S NAME Unknown 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE  
Unknown M Unknown  
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT Address  
Mr. & Mrs. Alvin Wynn 2905 Forest

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) *Atherosclerotic Heart Disease*  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) \_\_\_\_\_  
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?  
4200 YES  NO

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 Month, Day, Year  
a.m. p.m.

20d. INJURY OCCURRED WHILE AT  NOT WHILE WORK  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 *May 1, 1959* 5/17/59 and last saw her alive on 5/17/59  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE *L. S. Daigle, M.D.* (Declarer's title) D 22b. ADDRESS 22c. DATE SIGNED  
2122 Truman Rd. 5/17/59  
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State)  
Removal May 17, 59 K. C. College Osteo. Kansas City, Mo.

24. FUNERAL DIRECTOR ADDRESS 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE  
Lawrence A. Jones 2304 Vine 5-18-59 *new Marshall*

(Licensed Embalmer's Statement on Reverse Side)

300  
-57

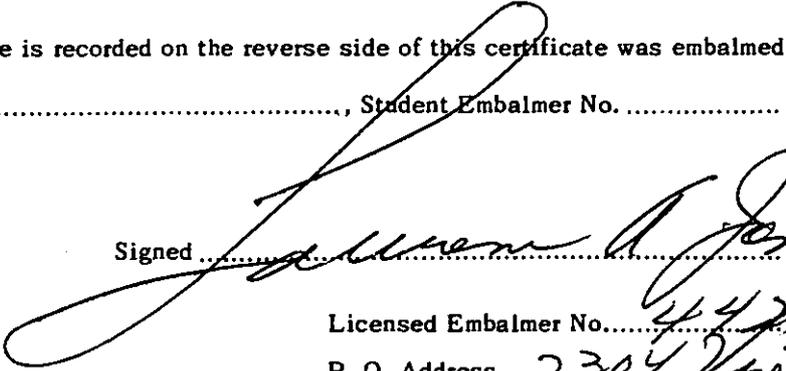
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
L. S. Daigle

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  .....

Licensed Embalmer No. .... 447

P. O. Address .... 2304 2nd

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.