

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-021773

STATE FILE NUMBER 2962

FILED JUL 8 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2962

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|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>                  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>   |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>Kansas City</b><br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Gen. Hospital</b>   |                                  | Length of stay in lb<br><b>25 yrs</b>   | d. STREET ADDRESS (If outside, give location)<br><b>1615 Virginia</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Charlie</b> Middle Last <b>Williams</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>6</b> Day <b>11</b> Year <b>59</b>   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b> | 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><b>8/17/94</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Construction</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><b>64</b><br>IF UNDER 1 YEAR: Months Days<br>IF UNDER 24 HRS.: Hours Min.  |
| 11a. FATHER'S NAME<br><b>Horace Williams</b>  |                                  | 11b. MOTHER'S MAIDEN NAME<br><b>Inez Johnson</b>  | 11. BIRTHPLACE (City and state or country)<br><b>Bryant Tex</b>   |
| 13a. FATHER'S NAME  |                                  | 14. NAME OF HUSBAND OR WIFE<br><b>Inez Williams</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>500-03-9404</b>   | 17. INFORMANT<br><b>Horace Williams</b> Address <b>I421 E 22</b>  |
| 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) <b>Congestive heart failure</b>  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>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)<br><b>Pyelonephritis</b>  |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 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.)<br><b>4341</b>   |   |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.   |                                  | 20d. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.)  |   |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |
| 21. I attended the deceased from <b>6-10-59</b> to <b>6-11-59</b> and last saw <sup>him</sup> alive on <b>6-11-59</b><br>Death occurred at <b>10:37 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |
| 22a. SIGNATURE<br><i>Abraham Gelperin</i> (Degree or title)   |                                  | 22b. ADDRESS<br><b>General Hospital</b>   | 22c. DATE SIGNED<br><b>6-17-59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>6/17/59</b>      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Blue Ridge Lawn</b>  | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City Mo</b>  |
| 24. FUNERAL DIRECTOR<br><b>Manlove-Willia qms</b> ADDRESS <b>I729 Lydia</b>   |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>6-17-59</b>  | 26. REGISTRAR'S SIGNATURE<br><i>Neva Minshall</i>   |

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

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 ..... *W. J. ...*

Licensed Embalmer No. *4653* .....

P. O. Address *TC* .....

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.