

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025515

FILED VS JUL 31 1959

Registration District No. 49 Primary Registration District No. 1002 Registrar's No. 3476 STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO;</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>24 YRS. 9</u>		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>ST. MARYS HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>301 BELLEFONTAINE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>ALVIN</u> Last <u>WILLIAMS</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>13,</u> Year <u>1959</u>			
5. SEX <u>0</u> <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/35</u>	9. AGE (last birthday) <u>24</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAY-OUT MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SONKEN-GLAMBA</u>		11. BIRTHPLACE (City and state or country) <u>K.C. MO.</u>		
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>EDWARD WILLIAMS</u>		13b. MOTHER'S MAIDEN NAME <u>ELSIE B. PENDLETON</u>		
14. NAME OF HUSBAND OR WIFE <u>NELDA MAE WILLIAMS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of service) <u>YES 1/6/56</u>		16. SOCIAL SECURITY NO. <u>496-34-2693</u>		
17. INFORMANT <u>WILLIAM W; HAWK</u>		Address <u>815 BENTON K.C. MO;</u>		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>Respiratory paralysis</u>		DUE TO (b) <u>Sub-arachnoid hemorrhage</u>		DUE TO (c) <u>Congenital aneurysm - brain</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not referred to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)		
20c. TIME OF INJURY Hour <u>-</u> a.m. <u>-</u> p.m. <u>-</u>		Month, Day, Year <u>-</u>		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 <u>KANSAS CITY, MO.</u>		COUNTY <u>-</u> STATE <u>-</u>		
21. I attended the deceased from <u>7-13-59</u> to <u>7-13-59</u> and last saw <u>him</u> alive on <u>7-13-59</u> Death occurred at <u>10:00 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>228 Plaza Time Bldg</u>		
22c. DATE SIGNED <u>7-15-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>7/16/59</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>FLORAL HILLS CEM;</u>		23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MO.</u>		24. FUNERAL DIRECTOR <u>C. H. BLACKMAN & SON INC. K.C. MO.</u>		
25. DATE RECD. BY LOCAL REG. <u>7-15-59</u>		26. REGISTRAR'S SIGNATURE <u>neva minchell</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bert B. Bem

Licensed Embalmer No. 4656

P. O. Address H. E.

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.