

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 21 1959 *149*

3910 59-029383
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. *1002* Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <i>JACKSON</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MISSOURI</i> b. COUNTY <i>JACKSON</i>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <i>KANSAS CITY</i>		Length of stay in 1b <i>56 yrs.</i>	c. CITY OR TOWN <i>KANSAS CITY</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. JOSEPH Hosp.</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>5240 Lyons</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>CLARENCE EDGAR WILLIAMSON</i>			4. DATE OF DEATH Month Day Year <i>8 - 9 - 1959</i>			
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 3, 1880</i>	9. AGE (last birthday) <i>79</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARPENTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BUILDING</i>		11. BIRTHPLACE (City and state or country) <i>AURORA, NEBR.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13a. FATHER'S NAME <i>HIRAM F. WILLIAMSON</i>		13b. MOTHER'S MAIDEN NAME <i>MELISSA DENTON</i>		14. NAME OF HUSBAND OR WIFE <i>Lucy A. Williamson</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>495-07-4440</i>		17. INFORMANT Address <i>Lucy A. Williamson - 5240 Lyons</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Cerebral intraventricular hemorrhage</i>		<i>Approx 20 hrs.</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Injury</i>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related 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 checked="" 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.) <i>Fell striking head on concrete block.</i>	
20c. TIME OF INJURY Hour a.m. Month, Day, Year <i>8/9/59</i>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <i>K.C. Jackson, Mo.</i>
21. I attended the deceased from <i>8/8/59</i> to <i>8/9/59</i> and last saw him alive on <i>8/8/59</i> Death occurred at <i>8/9/59 St. Joseph Hosp. K.C. Mo.</i> Am on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Terrance Earl Van Buren M.D.</i>		22b. ADDRESS <i>5246 St. John</i>	22c. DATE SIGNED <i>8/10/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>8-12-1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>FLORAL HILLS</i>	23d. LOCATION (City, town, or county) (State) <i>KANSAS CITY, MISSOURI</i>
24. FUNERAL DIRECTOR ADDRESS <i>C.H. BLACKMAN & SON INC. K.C., Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>8-11-59</i>	26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>

DOCUMENT

BY AFFIDAVIT OF TESTATION FILED WITH BURIAL OR 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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bert B. Bee

Licensed Embalmer No. 465

P. O. Address D.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.