

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040473

FILED VS. NOV 17 1959

Registration District No. _____ Primary Registration District No. 1002 Registrar's No. 5179 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 26 yrs.		c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen. Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1831 1/2 Vine Street		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Zack Middle Williams Last Williams				4. DATE OF DEATH Month Oct. Day 24, Year 1959									
5. SEX Male		6. COLOR OR RACE Col.		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4/25/79		9. AGE (last birthday) 80		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Memphis, Tenn			12. CITIZEN OF WHAT COUNTRY U.S.				
13a. FATHER'S NAME unknown				13b. MOTHER'S MAIDEN NAME unknown				14. NAME OF HUSBAND OR WIFE Anna Williams					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 500-03-2215		17. INFORMANT Address Jackson County Welfare							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema of Brain DUE TO (b) Subarachnoid Hemorrhage DUE TO (c) Cerebral Sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cause of Subarachnoid Hemorrhage pending.										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 1b.)									
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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		COUNTY		STATE			
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Deputy coroner</i>				22b. ADDRESS <i>1618 Lydia Ave</i>				22c. DATE SIGNED <i>10/27/59</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-3-59		23c. NAME OF CEMETERY OR CREMATORY Highland		23d. LOCATION (City, town, or county) Kansas City, Mo.							
24. FUNERAL DIRECTOR Bedeau, Appleton & Jones, K.C., Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. 10-27-59		26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
W. M. Tillman

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.