

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1960

-60-035121

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4374

INDEXED

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON				
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 6 Wk		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3406 Prospect			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3406 Prospect		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle WILLIAMS Last				4. DATE OF DEATH Month August Day 22 Year 1960				
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-15-91	9. AGE (last birthday) 68 Yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Saw Mill		11. BIRTHPLACE (City and state or country) Arkansas, Ark.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Sam Williams			13b. MOTHER'S MAIDEN NAME Lucinda Petterson			14. NAME OF HUSBAND OR WIFE none		
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. 431 03 0119		17. INFORMANT Address Curley Williams 3406 Prospect			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease								
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 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.)				
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 8-20-60 to 8-22-60 and last saw ^{her} him alive on Aug. 20, 1960 Death occurred at 9:00 a. m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Dr. Marc R. Lamp				22b. ADDRESS 3503 Prospect ; K. C. Mo.			22c. DATE SIGNED 8/22/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-25-60	23c. NAME OF CEMETERY OR CREMATORY -		23d. LOCATION (City, town, or county) West Helena Ark.			
24. FUNERAL DIRECTOR Mrs. Meek's Mortuary			ADDRESS K. C. Mo.		25. DATE RECD. BY LOCAL REG. 8-25-60		26. REGISTRAR'S SIGNATURE H. L. Dwyer	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Marc R. Lamp

an. 1-

NE 4-6862

STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Millard B. O.

Licensed Embalmer No. 50

P. O. Address AC

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.