

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 31 1960 149

5183 -60-038610 STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>35 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2025 Spruce</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2025 Spruce</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>William Edwin Willson</b>			4. DATE OF DEATH Month Day Year <b>Oct. 14, 1960</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2/9/1884</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Watkins Products</b>		11. BIRTHPLACE (City and state or country) <b>Proctor, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
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13a. FATHER'S NAME <b>John A. Willson</b>		13b. MOTHER'S MAIDEN NAME <b>Amanda Reed</b>		14. NAME OF HUSBAND OR WIFE <b>Mary E. Willson</b>			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>487-10-1362</b>		17. INFORMANT Address <b>Mary E. Willson 2025 Spruce K.C.Mo.</b>			
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphoma of Stomach &amp; Metastasis to mediastinum</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Sideroblastic Anemia</b>					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		
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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 Month, Day, Year a.m. p.m.							

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
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21. I attended the deceased from **7-20-60** to **10-14-60** and last saw him alive on **9-30-60**  
Death occurred at **630 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <b>P. A. Klenberger MD</b>		22b. ADDRESS <b>5746 St John</b>		22c. DATE SIGNED <b>10/15/60</b>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/15/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Versailles Cemetery</b>		23d. LOCATION (City, town, or county) <b>Versailles, Missouri</b>		
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24. FUNERAL DIRECTOR ADDRESS <b>Earp &amp; Sons 4707 Truman Rd. K.C.</b>		25. DATE RECD. BY LOCAL REG. <b>10-15-60</b>		26. REGISTRAR'S SIGNATURE <b>H-L-Dwyer</b>		
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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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John B. Camp

Licensed Embalmer No. 293

P. O. Address W.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.