

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3245-61-025566
STATE FILE NUMBER

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

AMENDED

FILED JUL 26 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	Length of stay in 1b 18 years	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 Research Hospital		d. STREET ADDRESS (If outside, give location) 3246 Warwick Blvd.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First GUY Middle N M I Last WILLIAMS	4. DATE OF DEATH Month June Day 26 Year 1961
--	--

5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-21-92	9. AGE (last birthday) 68 years	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) lineman, ret.	10b. KIND OF BUSINESS OR INDUSTRY Pipe Line Co.	11. BIRTHPLACE (City and state or country) Pattonburg, Mo.	12. CITIZEN OF WHAT COUNTRY USA
---	---	--	---

13a. FATHER'S NAME Sam Williams	13b. MOTHER'S MAIDEN NAME Anne Huff	14. NAME OF HUSBAND OR WIFE Leona Williams
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	17. INFORMANT Address Mrs. L. Williams, K.C. Mo.
---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) mesenteric artery thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 days
DUE TO (b) atherosclerosis		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease conditioning given in PART I (a) Cancer of prostate - cystitis - abscessed teeth	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 **June 5, 1961** to **June 26, 61** and last saw her alive on **June 26, 1961**
Death occurred at **10:30 P. M.** on or after the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Jean B. Willoughby M.D.	22b. ADDRESS 5905 Main KC 13 Mo	22c. DATE SIGNED 28 June 61
--	---	---------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 30, 1961	23c. NAME OF CEMETERY OR CREMATORY I.F.O.O.F. Cemetery	23d. LOCATION (City, town, or county) Pattonburg, Missouri
--	-----------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS WAGNER FUNERAL HOME, K.C. Mo.	25. DATE RECD. BY LOCAL REG. 6-29-61	26. REGISTRAR'S SIGNATURE Ruth Long
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF **Jean B. Willoughby** MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

Wed 1- To 5 PM
St. Louis - 516 900

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 Alvin R. Haenschel

Licensed Embalmer No. 4159

P. O. Address K. C. Mo.

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.