

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041339

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5738 STATE FILE NUMBER

AMENDED

**FILED DEC 11 1961**

DATE AMENDED

INSTEAD OF

DOCUMENT

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> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>1 yr</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>2905 Forest</b>		d. STREET ADDRESS (If outside, give location) <b>3827 College</b>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Clayton</b> Middle <b>Thomas</b> Last <b>Williams</b>			4. DATE OF DEATH Month <b>11</b> Day <b>13</b> Year <b>61</b>			
---	--	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-11-89</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>retired</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Higginsville, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	-----------------------------------	--	---

13a. FATHER'S NAME <b>Clayton Williams</b>	13b. MOTHER'S MAIDEN NAME <b>Alice Drisden</b>	14. NAME OF HUSBAND OR WIFE <b>unknown</b>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	17. INFORMANT <b>Ella Perry 3829 College</b>	Address
---	---	---------

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>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>
DUE TO (b) <b>Arteriosclerotic Heart Disease/</b>		
DUE TO (c) _____		<b>several months</b>
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 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 <b>Higginsville</b>	COUNTY <b>Mo.</b>	STATE
--	--	---	----------------------	-------

21. I attended the deceased from **11/1/61** to **11/13/61** and last saw him alive on **11/13/61**  
Death occurred at **7:30** A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>George H. Tarr</b> (Degree or title)	22b. ADDRESS <b>2204 E. 18th Street</b>	22c. DATE SIGNED <b>11/16/61</b>
---	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>11-16-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Muncie</b>	23d. LOCATION (City, town, or county) (State) <b>Higginsville Mo.</b>
--	------------------------------	---	--

24. FUNERAL DIRECTOR <b>Watkins Bros. Funeral Home 18th Benton</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>11-16-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth H. Long</b>
---	---------	---	--

ITEM NO. SHOULD READ

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 by me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed B. Bruce R. Watkins

Licensed Embalmer No. 4500

P. O. Address 1800 Barton

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.