

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042196
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10374

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 24 1963

1. PLACE OF DEATH a. COUNTY		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 St. Louis		Length of stay in 1b 17 days	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (Do not include hospital, clinic, or institution) St. Louis Little Rock Hospital, Inc.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3932 Agnes St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Silas Middle - Last Williams			4. DATE OF DEATH Month October Day 17 Year 1963
5. SEX Male	6. COLOR OR RACE Colored	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-10-1906
9. AGE (last birthday) 57		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Welborne, Kansas
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Silas Williams	
13b. MOTHER'S MAIDEN NAME Rhoda Spruell		14. NAME OF HUSBAND OR WIFE Cleatrice Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) No		16. SOCIAL SECURITY NO. 3932 Agnes	
17. INFORMANT Cleatrice Williams - Kansas City, 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) Carcinomatosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Adenocarcinoma of the Prostate DUE TO (c) 177X	
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.	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 16, 1963 to October 17, 1963 and last saw him alive on Oct. 17, 1963 Death occurred at 1 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Deceased or title) R. D. [Signature] M.D.	
22b. ADDRESS 1755 S. Grand Blvd.		22c. DATE SIGNED 10/17/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/18/63	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR Watkins Funeral Home - Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. OCT 18 1963	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

DATE AMENDED
2

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

1

2 368

3

4 2

5 1

6

7 1

8 2

9

10

11

12 69-1

13

69

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 Thomas M. Watson

Licensed Embalmer No. **4479**
2205 Missouri Ave.
P. O. Address **East St. Louis, Ill.**

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.