

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

17233

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1007
 City Kansas City (No. 310 East Armour Blvd.) St. _____ Ward _____

File No. _____
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME Luke Ferrell Wilson

(a) Residence No. 310 East Armour Blvd. Ward 5
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. _____ mos. _____
 How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Nellie McCrory Wilson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 2, 1842

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
85 8 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Palestine
 (STATE OR COUNTRY) Illinois

10. NAME OF FATHER Isaac Newton Wilson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Moresfield
 (STATE OR COUNTRY) West Virginia

12. MAIDEN NAME OF MOTHER Hannah Harness

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Romney
 (STATE OR COUNTRY) West Virginia

14. INFORMANT Miss Gertrude Neal
 (Address) 310 East Armour Blvd.

15. FILED 5/18/28 M. M. Cronin
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 17 19 28

17. I HEREBY CERTIFY That I attended deceased from Jan 1, 1928, to May 16, 1928
 that I last saw him alive on May 16, 1928, and that death occurred, on the date stated above, at 3:45 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

82 Central Nervous System
III B 7401
 (duration) yrs. _____ mos. 10 ds. _____
 CONTRIBUTORY (SECONDARY) Pneumonia Hypostatic
breathless on labor (duration) yrs. _____ mos. 3 ds. _____

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) W. O. Chambers, M. D.
5/18, 1928 (Address) 800 West 13th St

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Charleston, Ill DATE OF BURIAL 19
May 18 19 28

20. UNDERTAKER Stine + M. Clare Tubb ADDRESS 924 Oak

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FADING INK—THIS IS A PERMANENT RECORD

272 06/18

800 Rialto Bldg.,

Hours-- 2-5