

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

Do not use this space.

12552

1. PLACE OF DEATH

County De Waver Registration District No. 305 File No. _____
 Township De Waver Primary Registration District No. 100 Registered No. 1475
 City Kansas City (No. Kansas City, Agnes Hosp) St. _____ Ward _____

2. FULL NAME

Nellie Wilson
 (a) Residence. No. 3118 E 52nd St., 16 Ward. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Fred N. Wilson</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 29 1878</u>				
7. AGE	YEARS <u>56</u>	MONTHS <u>7</u>	DAYS <u>2</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

PARENTS	10. NAME OF FATHER <u>Tom Stacey</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>England</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>England</u>

14. INFORMANT Fred N. Wilson
 (Address) 3118 E 52nd St.

15. FILED 4/3, 1930 M.M. Cronie
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-1 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-31 1930 to 4-1 1930
 that I last saw him alive on 4-1 1930 and that death occurred, on the date stated above, at 5:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Scarlet Fever
8 9 513
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Cardiac decompensation
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) J. H. Jewell, M. D.
4-1 1930 (Address) Subt. K. C. Gen. Hosp

*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 Memorial Park DATE OF BURIAL 4/2 1930

20. UNDERTAKER L.W. Newcomer's ADDRESS 2111 E 9th

K. 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.

WRITE PLAINLY, WITH UNPADDED INK—THIS IS A PERMANENT RECORD

