

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

Do not use this space.

12855

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township St. Lawrence Primary Registration District No. Wesley Hosp
 City Kansas City (No. Wesley Hosp)
2. FULL NAME Albert M. Wilson
 (a) Residence No. 926 7th St. 6 Ward. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. 1734
 Registered No. 1734
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m **4. COLOR OR RACE** wh **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF Nellie Krepso Wilson
 (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 23, 1894
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
75 | 9 | 29 | _____ | _____ | _____
8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Physician
 (b) General nature of industry, business, or establishment in which employed (or employer) 137
97
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Ind.
 (STATE OR COUNTRY) _____
10. NAME OF FATHER Thos True Wilson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Sarah Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) _____

14. INFORMANT Mrs Nellie Krepso Wilson
 (Address) 926 7th St
15. FILED 4/23 1930 M. M. Brown
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 22 1930
17. I HEREBY CERTIFY, That I attended deceased from Apr 26, 1930, to April 22, 1930 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 8:30 a. m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Adenomatous Hypertrophy of Prostate Gland
 (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Arteriosclerosis
 (duration) _____ yrs. 1 mos. 24 ds.
18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT A PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? Cystoscopic Exam
 (Signed) Julius F. Fisher, M. D.
April 22, 1930 (Address) 331 Father's Bldg

*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 Forest Hill Park DATE OF BURIAL Apr 23 1930
20. UNDERTAKER St. Newcomer's Sons ADDRESS 116 2nd

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.

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

