DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FEB 19 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2577

Registration District No. 398 Primary Registration District No. 3019 Registrar's No. 10

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Independence (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 625 W. Maple (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 25 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Independence (If outside city or town limits, write "RURAL")

(d) Street No. 625 W. Maple (If rural, give location)

(e) If foreign born, how long in U. S. A.? Lifetime years.

3. (a) PRINT FULL NAME Robert Park Wilson

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lena H. Wilson

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June 13, 1883 (Month) (Day) (Year)

8. AGE: Years 58 50 Months 6 Days 25 If less than one day hr. min.

9. Birthplace Platte Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Policeman

11. Industry or business City of Independence

FATHER 12. Name Jacob Wilson 0

13. Birthplace no history (City, town, or county) (State or foreign country) 0

MOTHER 14. Maiden name Kate Wilson 0

15. Birthplace no history (City, town, or county) (State or foreign country) 1

16. (a) Informant's own signature Kenneth Wilson

(b) Address 205 W. Stone, Indep. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Longanoxie, Kans.

18. (a) Signature of funeral director Cato & Speaks

(b) Address 304 So Grand, Indep. Mo.

19. (a) Jan 10 1940 (Date received local registrar) (b) F. L. Cook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8 year 1940 hour 6 minute 30 A M.

21. I hereby certify that I attended the deceased from June, 1939, to Jan 8, 1940, that I last saw him alive on Jan 8, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion ~~Coronary Sclerosis~~	3 hrs
Due to Coronary Sclerosis	—
Due to 9410	
Other conditions Arterial hypertension (Include pregnancy within 3 months of death)	?

Major findings: Of operations X

Of autopsy X

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? No (Specify type of place)

While at work? No (e) Means of injury —

23. Signature Chas. A. Grabske (M. D. or other) MD

Address Independence Mo. Date signed 1/8/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

I X19511

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed Roland P. Speaks

Licensed Embalmer No. 3604

P. O. Address Indep. Mo.

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

25-77
Do not use this space.

1. PLACE OF DEATH
(a) County: Jackson — Registration District No.: 38
(b) Township: — Primary Registration District No.: 3019 — Registered No.:
(c) City: Independence (d) Street No.: St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: Robert Park Wilson
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): June 13-1883

7. AGE — YEARS: 56 — MONTHS: 6 — DAYS: 25 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 12 1940 F. L. Cook Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Jan 8, 1940

22. I HEREBY CERTIFY, That I attended deceased from ....19.... to ....19....
I last saw h.... alive on ....19.... Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation .... Date of ....
What test confirmed diagnosis? .... Was there an autopsy? ....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? .... Date of injury ....19....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Chas Graham, M. D.
(Address) Independence Mo

SUPPLEMENTARY

Corrected March 13-1940

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.