FILED APR 12 1940

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

9981
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township Kaw — Primary Registration District No. 1002 — Registered No. 1415
(c) City Kansas City, Mo. — (d) Street No. St. Vincent's Hospital 3210 E. 23rd St., 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 425 Infant Chilson (Infant Chilson)
(a) Residence, No. 1650 Jackson 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: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Infant

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): March 29, 1940.

7. AGE — YEARS: XXXXXXXXXXX — MONTHS: XXXX — DAYS: XXX — If LESS than 1 day, hrs. or 30 min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: None
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): Kansas City, Missouri. 0

FATHER
13. NAME: Mr. Joseph Chilson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kansas City, Missouri. 0

MOTHER
15. MAIDEN NAME: Mary Jo Powers
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Harrison, Arkansas. 1

17. INFORMANT (ADDRESS): Ed. F. Powers 1822 Norton

18. BURIAL, CREMATION, OR REMOVAL
PLACE Green Lawn DATE 3-30 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Rose & Henderson 15th & Jackson

20. FILED Mch 31, 1940 — M. M. Crowe, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): March 29, 1940

22. I HEREBY CERTIFY, That I attended deceased from 3/29, 1940, to 3/29/40, 19
I last saw h alive on 3/29/40, 19 Death is said to have occurred on the date stated above, at 11 a m.
The principal cause of death and related causes of importance were as follows:

Premature 6 mo — Date of onset

151

Other contributory causes of importance:

Name of operation no — 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? no
If so, specify
(Signed) Joseph Nahlen M. D.
(Address) 1103 Grand

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

V. S. No. 2. 50M-1-12-38 I X14028

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, 3-30-40 Van Lawson Ayres, or by _____,

Registered Apprentice No._____, working under my personal supervision.

Signed G. E. Henderson

Licensed Embalmer No. 3657

P. O. Address K. C. 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.