No. 2
11-10-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24418

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 3028

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: K.C.General Hospital No.1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Mo. & 23 days (Specify whether
In this community 14 Years.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1927 Poplar
(If rural, give location)

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

3. (a) PRINT FULL NAME VIRGINIA WILSON 425

3. (b) If veteran, name war No.

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Lee Wilson,

6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased Born Missouri, Jan. 7th, 1907
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
33	6 -	- 19	hr. min.

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

10. Usual occupation Clerk in Store

11. Industry or business Housewife

FATHER
12. Name William Patterson,
13. Birthplace Missouri
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lillian Vaughn
15. Birthplace Missouri.
(City, town, or county) (State or foreign country)

16. (a) Informant Lee R. Patterson, Bro.
(b) Address Kansas City, Mo. 1927 Poplar, Av.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July- 30-40
(Month) (Day) (Year)
(c) Place: burial or cremation Maple Cem. at Oregon, Mo.

18. (a) Signature of funeral director Mrs. C. L. Forster
(b) Address 918 Brooklyn Avenue, K.C.Mo.

19. (a) July 29, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26th
year 1940 hour 7 minute 50 A. M.

21. I hereby certify that I attended the deceased from June 3rd, 1940, to July 26th 1940, 19__;
that I last saw her alive on July 26th, 1940, 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death INSULIN SHOCK

84

Due to Schizophrenia

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy See above

Duration

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Dewey R Thomas (M.D. or other)
Address Med.Dir.K.C.Gen.Hospital K.C.Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 E. H. Wise

Licensed Embalmer No. 2578

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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