

No. 2
4-13-40
-17-39
I X23159

Registration District No. 399

1002

Registrar's No. _____

MAILED AUG 14 1940

1. PLACE OF DEATH: Jackson /
 (a) County: Kansas City
 (b) City or town: Kansas City
 (c) Name of hospital or institution: St. Mary's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: 35 Yrs.
 In this community: 35 Yrs.
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME: William Roy Wonn 580

3. (b) If veteran, name war: ----- 3. (c) Social Security No. 703-03-8714

4. Sex: Male 5. Color or race: white 6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Ada Wonn 6. (c) Age of husband or wife if alive: 65 years

7. Birth date of deceased: December 15, 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	7	13	hr. min.

9. Birthplace: Portsmouth Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation: Foreman

11. Industry or business: Kansas City Terminal

12. Name: William Wonn

13. Birthplace: Pennsylvania
(City, town, or county) (State or foreign country)

14. Maiden name: Mary Walter

15. Birthplace: Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Ada Wonn

(b) Address: 4011 E. 17th

17. (a) burial (b) Date thereof: 7-31-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Moriah

18. (a) Signature of funeral director: Gates Funeral Home

(b) Address: Kansas City, Kansas

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

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.: 4011 East 17th
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.: _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: July day: 28 -
year: 1940 hour: 1:30 P.M. minute: _____ M.

21. I hereby certify that I attended the deceased from May 27 -
1940, 19____, to July 28 - 1940.
that I last saw him alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Subacute Nephritis
Uremia - Carcinia -
Auricular fibrillation

Due to: _____
Due to: 131

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____
 Of autopsy: _____

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: M. M. Crove (M. D. or other) _____
Address: _____ Date signed: _____

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

Dr. Max Goldman
Professional Bldg.
3-6

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Ross Blanford

Licensed Embalmer No. *4015*

P. O. Address *21148 State Line*

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, fact should be so stated above.