

FILED SEP 12 1941
Registration District No. _____

Primary Registration District No. **1002**

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:
2310 Denver
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **55 Years** / (Specify whether 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. **2310 Denver**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Ira F. Wilson**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **Whitr** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Sarah Francis Wilson** 6. (c) Age of husband or wife if alive **76** years

7. Birth date of deceased **April 27, 1861**
(Month) (Day) (Year)

8. AGE: Years **80** Months **3** Days **19** If less than one day _____ hr. _____ min.

9. Birthplace **Genava, Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Real Estate Co**
Self

11. Industry or business **Self**

12. Name **Thomas Wilson**

13. Birthplace **England**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Appleyard**

15. Birthplace **England**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Sarah F. Wilson**

(b) Address **2310 Denver**

17. (a) **Burial** (b) Date thereof **Aug. 24, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt/ Washington**

18. (a) Signature of funeral director **Mrs. C. L. Forster**

(b) Address **918 Brooklyn**

19. (a) **8/18/41** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **16**
year **1941** hour **12** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **Jan 1941** to **Aug 16 1941**
that I last saw him alive on **Aug 16 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Chronic pulmonary edema - 1 Pa**
Ch. Myocardial Infarct
Due to **Ch. Myocardial Infarct**
Ch. Myocardial Infarct
Due to **Smoking - (Chestnut)**

Other conditions: **131 B**
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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?

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

23. Signature **D. P. Green** (M. D. or other) **10**
Address **4400 E 24th** Date signed **8/16/41**

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

MOTHER FATHER

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.....

Licensed Embalmer No. 4139

P. O. Address Rt. 6. 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, fact should be so stated above.