

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

AUG 11 1943
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3263

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: St. Luke's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 21 Days
(Specify whether years, months or days)
 In this community 1 Month

2. USUAL RESIDENCE OF DECEASED:
 (a) State Kansas (b) County Cherokee
 (c) City or town Weir
(If outside city or town limits, write "RURAL")
 (d) Street No. --
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country --

3. (a) PRINT FULL NAME Mrs. Ruby Agnes Wilkinson
 3. (b) If veteran, name war No
 3. (c) Social Security No. None

4. Sex Female
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mr. William Wilkinson
 6. (c) Age of husband or wife if alive 58 years
 7. Birth date of deceased March 1 1885
(Month) (Day) (Year)

8. AGE: Years 58.50 Months 4 Days 25
If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business --

12. Name Vincent Putman

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

14. Maiden name Alice Vincent

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

16. (a) Informant Miss Alice Wilkinson

(b) Address 401 East Armour Blvd.

17. (a) Removal (b) Date thereof July 27, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Weir, Kansas

18. (a) Signature of funeral director D. W. Newcomer, Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 7-26-43 (b) P. E. Brown
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 25
 year 1943 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from Pathologist
 that I last saw him alive on _____, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Paralytic ileus
 Due to _____
 Due to _____
 Other conditions Terminal Pulmonary edema
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy as above

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 Maurice L. Jones (M.D. optional)
 Address St. Luke's Hosp. Date signed 7-25-43

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

Signed Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC 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.