V. S. No. 2
00M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24143

AUG 11 1943

Registration District No. 149 — Primary Registration District No. 1002 — Registrar's No. 3318

1. PLACE OF DEATH:

(a) County: Jackson

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

(c) Name of hospital or institution: 1223 Fremont (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community 50 years

2. USUAL RESIDENCE OF DECEASED: 48

(a) State: Missouri (b) County: Jackson 3

(c) City or town: Kansas City, Mo. (If outside city or town limits, write "RURAL") 8

(d) Street No.: 1223 Fremont (If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No) No

If yes, name country ____

3. (a) PRINT FULL NAME: Mrs. Laura Elizabeth Wilson

3. (b) If veteran, name war: --

3. (c) Social Security No.: none

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: William Wilson

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

7. Birth date of deceased: July 28, 1862 (Month) (Day) (Year)

8. AGE: Years 81 | Months 0 | Days 1 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Homemaker

11. Industry or business: At Home

FATHER
12. Name: Tracey Shepherd
13. Birthplace (City, town, or county) Ill (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace (City, town, or county) Unknown (State or foreign country) 9

16. (a) Informant: Mrs. Bert Driscoll

(b) Address: 1223 Fremont, K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-43 (Month) (Day) (Year)

(c) Place: burial or cremation: Shawnee, Ks.

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

(b) Address: K.C. Mo.

19. (a) 7-30-43 (Date received local registrar) (b) Dep. T.E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29 year 1943 hour 5 minute ____ A. M.

21. I hereby certify that I attended the deceased from July 15, 19 43 to July 29, 19 43 that I last saw him alive on July 29, 19 43 and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac failure — Duration

Due to: cerebral hemorrhage

Due to: senility 8 30

Other conditions (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: Chas. J. Fry, MD (M. D. or other)

Address: 130 Lee Bldg. Date signed 7/30/43

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.