

ED NOV 1 1943/49
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: 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 7 days
(Specify whether years, months or days) 18 mo.

3. (a) PRINT FULL NAME Shifflett, Wilson

3. (b) If veteran, name war Mo 3. (c) Social Security No. 929-10-48

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Mar 1

6. (b) Name of husband or wife Annabelle 6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased Mar 29 1912
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
31 6 7 hr. _____ min.

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

10. Usual occupation Carpenter & roofer

11. Industry or business Anchor Roofing Co

12. Name Dr. Wm Shifflett

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

14. Maiden name Marion M Shifflett

15. Birthplace Low Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Annabelle Shifflett

(b) Address 423 Norton

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-43
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director G. H. Blackman

(b) Address 11-E. Brown

19. (a) 10-7-43 (Date received local Registrar) (b) W. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 423 Norton
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6th
year 1943 hour 8 minute 20 A. M.

21. I hereby certify that I attended the deceased from Sept. 29th 1943 to Oct. 6th 1943
that I last saw him alive on Oct. 6th 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Poliomyelitis
(Bulbar in type) Duration _____

Due to _____ 36

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 Dr. Wm Shifflett (M. D. or other) 10-7-43
Address Med. Dir. Gen'l Hosp. Date signed _____

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

MOTHER FATHER

APR 24 1945

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.