

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1992
Registrar's No.

FILED MAY 11 1944
Registration District No. 149

Primary Registration District No. 1002

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

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: Kansas City T. B. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months
In this community 37 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME ROBERT SIMPSON WILSON
3. (b) If veteran, name war - no
3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Dead 6. (c) Age of husband or wife if alive Dead years
7. Birth date of deceased: (Month) 29 (Day) 1906 (Year)

8. AGE: Years 37 Months 7 Days 5 If less than one day hr. min.

9. Birthplace: Kansas City Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Electrician

11. Industry or business

MOTHER FATHER
12. Name R. H. Wilson
13. Birthplace Kentucky (State or foreign country)
14. Maiden name Esther Turner
15. Birthplace Manchester Ill. (State or foreign country)

16. (a) Informant Patrol
(b) Address H. C. F. B. Hosp

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 6-44
(City or town) (County) (State) (Day) (Year)

(c) Place: burial or cremation Floral Hills Cem.

18. (a) Signature of funeral director Wm. G. Garrison
(b) Address Indep. Endue. Ins

19. (a) 5-6-44 (Date received local registrar) (b) W. C. Brown (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. 2711 Sterling
(If rural, give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 5 day 4
year 1944 hour 8 minutes 14 A. M.
21. I hereby certify that I attended the deceased from 2-2-44
1944 to 5-4 1944
that I last saw him alive on 5-4 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary T.B.
Duration 3 yr. and 3 mo.

Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations
Of autopsy 136
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 W. C. Garrison (M. D. or other)
Address H. C. F. B. Hosp. Date signed 5-4-44

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 George C. Parson
Licensed Embalmer No. 2249
P. O. Address Independence, 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.