

S. No. 2
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7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **4276**

Registration District No. **1002**

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: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 24 hours
(Specify whether
 In this community 16 years
years, months or days)

3. (a) PRINT FULL NAME JAMES (JIM) WILSON
 3. (b) If veteran, name war no
 3. (c) Social Security No. 487-09-9836

4. Sex Male 0
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife May E. Wilson
 6. (c) Age of husband or wife if alive 36 years
 7. Birth date of deceased October 8 1905
(Month) (Day) (Year)

8. AGE: Years 39 Months 0 Days 8
 If less than one day _____ hr. _____ min.

9. Birthplace New Castle England 4
(City, town, or county) (State or foreign country)

10. Usual occupation Maintenance Man

11. Industry or business Oldsmobile Div.

MOTHER FATHER {
 12. Name George H. Wilson 4
 13. Birthplace England 4
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant May E. Wilson

(b) Address 1931 Sterling

17. (a) Burial (b) Date thereof 10-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Cemetery
George C. Carson

18. (a) Signature of funeral director Independence, Mo.

(b) Address _____

19. (a) 10-19-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson 48
 (c) City or town Independence 4
(If outside city or town limits, write "RURAL")
 (d) Street No. 1931 Sterling 4
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 16
 year 1944 hour 6 minute 30 A.M.

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

Immediate cause of death... Second degree burns of face arms and hands
 Due to _____

Due to Flood Exposure

Other conditions 181-1
(Include pregnancy within 3 months of death)

Major findings: 181-1
 Of operations _____
 Of autopsy Injuries

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) Accident 136

(b) Date of occurrence October 16, 1944

(c) Where did injury occur? 10715/44
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Industry

While at work? Yes (Specify type of place) (e) Means of injury 10715/44

23. Signature [Signature] 3 (M. D. or other)

Address [Address] Date signed 10/17/44

NOV 28 1944

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 *Dean Owens*.....

Licensed Embalmer No. *4288*.....

P. O. Address *Indep. 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.