

**LED DEC 4 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 **St. Joseph's Hbospital**  
(If not in hospital or institution, write street number or location) **0**  
 (d) Length of stay: In hospital or institution **9 Weeks** (Specify whether  
 In this community **45 Years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Jackson** **47**  
 (c) City or town **Kansas City** **3**  
(If outside city or town limits, write "RURAL.") **8**  
 (d) Street No. **4612 Chestnut**  
(If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No)  
 If yes, name country \_\_\_\_\_ **11**

3. (a) PRINT FULL NAME **EMMA BLANCHE WILSON**  
 (b) If veteran, name war **No**  
 (c) Social Security No. **None**

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **Nov.** day **13**  
 year **1944** hour **1** minute **15 A.M.**

4. Sex **Fe.** 5. Color or race **White**  
 6. (a) Single, widowed, married, divorced **Married**  
 (b) Name of husband or wife **Earl** (c) Age of husband or wife if alive **52** years  
 7. Birth date of deceased **May 13, 1895**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept. 21, 1944, to Nov. 11, 1944;**  
 that I last saw him alive on **Nov. 11, 1944;**  
 and that death occurred on the date and hour stated above.

8. AGE: Years **49** Months **6** Days **0** If less than one day  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death  
**Regulatory paralysis** **3 hrs.**  
**Tumor of brain metastatic** **9 mos.**  
**Pulvic carcinoma** **?**

9. Birthplace **Kansas**  
(City, town, or county) (State or foreign country)  
 10. Usual occupation **Homemaker**  
 11. Industry or business **None**

Other conditions (Include pregnancy within 3 months of death)  
**54**

MOTHER FATHER }  
 12. Name **Warren M. Cooley**  
 13. Birthplace **Indiana**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **Ordella Darling**  
 15. Birthplace **New York**  
(City, town, or county) (State or foreign country)

Major findings:  
 Of operations **None**  
 Of autopsy **None**  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Earl Wilson**  
 (b) Address **4612 Chestnut**  
 17. (a) **Burial** (b) Date thereof **Nov. 15, 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Mt. Moriah**

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? \_\_\_\_\_

18. (a) Signature of funeral director: **C. H. Blackman & Son,**  
 (b) Address **Kansas City**  
 19. (a) **11-14-44** (b) **D. E. Brown**  
(Data received local registrar) (Registrar's signature)

Inc While at work? \_\_\_\_\_  
(Specify type of place) (c) Means of injury  
 23. Signature **D. E. Brown** (M. D. or other) \_\_\_\_\_  
 Address **1418 Professional Bldg., K.C., Mo.** Date signed **Nov. 14, 1944**

Dr. B. Landis Elliott

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**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.**