

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. **149**

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:
General Hospital #2 **0**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **11-27-44-12-2-44**
(Specify whether years, months or days) **13 years**

3. (a) PRINT FULL NAME WILBUR LYNN

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **Male** 2. Color or race **Negro**

6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife

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

7. Birth date of deceased **April 3 1931**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
13	7	29	hr. _____ min.

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

10. Usual occupation **Unemployed**

11. Industry or business _____

MOTHER FATHER

12. Name **X** **9**

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

14. Maiden name **But h Lynn**

15. Birthplace **Leone Knorr** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**

(b) Address **General Hospital #2**

17. (a) **Burial** (b) Date thereof **12-14-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln Cemetery**

18. (d) Signature of funeral director **Brady Brown**

(b) Address **1708 Brady**

19. (a) **12-14-44** (b) **P. C. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson** **42**

(c) City or town **Kansas City Little Blue**
(If outside city or town limits, write "RURAL")

(d) Street No. **Boys Home**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **2**
year **1944** hour **8:30** minute **a.** M.

21. I hereby certify that I attended the deceased from **November 27**
19**44** to **December 2** 19**44**
that I last saw h. **1m** alive on **December 2** 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumococcal peritonitis** Duration _____

Due to **Chronic Nephrosis**

Due to _____

Other conditions **13/15**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **Same as above**

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? _____

While at work? _____ (Specify type of place)
Means of injury _____

23. Signature **P. C. Brown** (M. D. or other)
Address **Gen. Hosp. #2 600 E. 22nd** Date signed **12-5-44**

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

48368

Missouri

STATEMENT BY LICENSED EMBALMER

Boydell, Mo

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. 1271

P.O. Address Kansas City 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.