

U.S. No. 2
FORM-5-43
Rev. 5-17-39
1 X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 20 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17691

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2053

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:
3114 Garfield
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No (Specify whether years, months or days)

In this community... 28 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 80

(d) Street No. 3114 Garfield (If rural, give location) 0

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Maria J Wilson

3. (b) If veteran, name war No

3. (c) Social Security No. N/A

4. Sex Female 5. Color or race Wht

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

6. (b) Name of husband or wife John Wilson

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Apr 27 1849
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7 year 1947 hour 7 minute 30 P M.

21. I hereby certify that I attended the deceased from Apr. 29 1947 to 7 May 1947

that I last saw her alive on May 6 1947 and that death occurred on the date and hour stated above.

8. AGE:

| Years | Months | Days | If less than one day |
|-----------|----------|----------|-----------------------------|
| <u>98</u> | <u>8</u> | <u>9</u> | <u>0</u> hr. <u>10</u> min. |

Immediate cause of death Bronchial pneumonia 5 days

Due to Haemic terminal 5 days

Due to _____

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

Other conditions (Include pregnancy within 3 months of death) no

10. Usual occupation at home

11. Industry or business _____

12. Name Daniel Cooper

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

14. Maiden name Gandy

15. Birthplace unknown
(City, town, or county) (State or foreign country)

Major findings: Of operations no

Of autopsy no 107

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. J. B. Robinson

(b) Address 51 W. Wornall Rd

17. (a) _____ (b) Date thereof 5/8/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harlin

18. (a) Signature of funeral director Stine-McClure

(b) Address Kansas City Mo

19. (a) 5-8-47 (b) sterling Adema
(Date received local registrar) (Registrar's signature)

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 office) (e) Means of injury _____

23. Signature Loyce W. ... (M.D. or other) MD

Address 4006 Patterson Date signed May 7

(Licensed Embalmer's Statement on Reverse Side)

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

40 Baltimore
Wm. H. H. H. H.

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 Robert H. Reed

Licensed Embalmer No. 3745

P. O. Address. 14c. 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.