

FILED DEC 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37579

4947

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| BIRTH NO. | | REG. DIST. NO. 149 | | PRIMARY REG. DIST. NO. 1002 | | Registrar's No. 4947 | |
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Kansas City | | c. LENGTH OF STAY (in this place) 5.3 YRS | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | | 753 753 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 5437 Forest | | | | d. STREET ADDRESS (If rural, give location) 5437 Forest | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Ella | | b. (Middle) F | | c. (Last) Wilson | | 4. DATE OF DEATH (Month) (Day) (Year) Nov 19, 1949 | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow | | 8. DATE OF BIRTH July 29, 1867 | |
| 9. AGE (In years last birthday) 82 | | IF UNDER 1 YEAR Months | | IF UNDER 24 HRS. Days | | Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME Wm. Fennell | | 13b. MOTHER'S MAIDEN NAME Mary O'Connor | | 14. NAME OF HUSBAND OR WIFE Horace D. Wilson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS C.A. Mr. Fennell 5437 Forest K.C., Mo. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of the Lungs + Spine ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of the Breast DUE TO (c) Arterio-sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year 5 yrs 10 yrs | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 1701 | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from March, 1949, to Nov 19, 1949 that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE Don Carlos Peete (Degree or title) Don Carlos Peete M.D. | | | | 23b. ADDRESS 1500 Prof Bldg | | 23c. DATE SIGNED 11-20-49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 11-21-49 | | 24c. NAME OF CEMETERY OR CREMATORY Mt. Washington | | 24d. LOCATION (City, town, or county) (State) Kansas City Mo. | |
| DATE REC'D BY LOCAL REG. 11-21-49 | | REGISTRAR'S SIGNATURE Seraldine Holmes | | 25. FUNERAL DIRECTOR'S SIGNATURE Stine & McClure | | ADDRESS K. C. Mo. | |

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

10-20-17

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *J. Allen*

Licensed Embalmer No. 1415

P. O. Address *H. C. W.*

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.