

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1567

State File No.

FILED FEB 9 1952

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 415

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City	c. LENGTH OF STAY (in this place township) 65 years	c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Krestwood Medical Hosp.		d. STREET ADDRESS 5045 Agnes	

3. NAME OF DECEASED (Type or Print) William Wilkinson			4. DATE OF DEATH (Month) (Day) (Year) Jan. 25, 1952		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 3, 1860		9. AGE (In years last birthday) 91 years
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? -

13a. FATHER'S NAME Fred Wilkinson		13b. MOTHER'S MAIDEN NAME Ellen Stemp		14. NAME OF HUSBAND OR WIFE Fannie Crabtree Wilkinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME, ADDRESS John Tillmon Wilkinson 5045 Agnes	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 45th	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 Jan 23, 1952 to Jan 25, 1952 that I last saw the deceased alive on Jan 23, 1952 and that death occurred at 7:15 A.M. from the causes and on the date stated above.

23a. SIGNATURE D. F. Hogan		23b. ADDRESS 801 1/2 W 39th St		23c. DATE SIGNED 1-25-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 28, 1952		24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery	
24d. LOCATION (City, town, or county) (State) Kansas City, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thos. E. Quirk 4316 Troost Ave.			

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

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Licensed Embalmer No.

Signed.....
Student Embalmer

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.