

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21797**
Registrar's No. **2632**

FILED JUN 23 1953

REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 2632		
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution.) a. STATE Kansas b. COUNTY Wyondotte				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 14 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City,				
d. FULL NAME OF HOSPITAL OR INSTITUTION Polyclinic 262 1/2 Indp Ave.				d. STREET ADDRESS (If rural, give location) 2212 So. 38 St.				
3. NAME OF DECEASED (Type or Print) a. (First) Benjamin		b. (Middle) Harrison		c. (Last) Wilson		4. DATE OF DEATH (Month) (Day) (Year) May 21 1953		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug 13 1889		
9. AGE (In years last birthday) 63		# UNDER 1 YEAR (Months) 0		# UNDER 1 YEAR (Days) 0		# UNDER 1 MIN. (Hours) 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter helper			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) Missouri		
12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME William Wilson		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Marie Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 499-20-2628		17. INFORMANT'S SIGNATURE OR NAME William Wilson ADDRESS 3804 Gibbs Kas. City Ks.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Lung Hemorrhage MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH								
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lung Hemorrhage								
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Lobar Pneumonia. DUE TO (c) Carcinoma of right lung. Primary								
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 0102X								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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)		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 February 7, 1950 , to May 21, 1953 , that I last saw the deceased alive on May 7, 1953 , and that death occurred at 11:00 AM , from the causes and on the date stated above.								
23a. SIGNATURE (Print name and title) Dr. R. DeSoto, D.O.				23b. ADDRESS 2301 Summit		23c. DATE SIGNED May 21, 1953		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE May 23 1953		24c. NAME OF CEMETERY OR CREMATORY Mt Hope Cem.		24d. LOCATION (City, town, or county) (State) Mound City, Missouri		
DATE REC'D BY LOCAL REG. 5-22-53		REGISTRAR'S SIGNATURE Heraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE Mrs C.L. Forster ADDRESS Funeral Home K.C. Mo.				

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

mi 03/18

VS
AUG 24 1960

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 *Dean Owens*

Licensed Embalmer No. *4280*

P. O. Address *Id. C. 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.