

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013626
STATE FILE NUMBER
1686

FILED APR 20 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

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-57 0

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 OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Queen of the World Hosp		d. STREET ADDRESS (If outside, give location) 3119 E 19th Terr	

3. NAME OF DECEASED (Type or print) First Middle Last Delores Diane Wilson			4. DATE OF DEATH Month Day Year APR 15 1959		
5. SEX Girl	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 24 1959		9. AGE (In years last birthday) 1 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, stop if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Kansas City, Mo.	

13a. FATHER'S NAME William S Wilson		13b. MOTHER'S MAIDEN NAME Delores Mack		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address William S. Wilson, K.C. Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURITY DUE TO PREMATURITY.			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) twin			
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
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21. I attended the deceased from 2-24-59 to 4-1-59 and last saw her alive on 4-1-59
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Starks J. Williams, M.D.		22b. ADDRESS 2462 A. Brooklyn Ave		22c. DATE SIGNED 4-2-59	
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-3-59		23c. NAME OF CEMETERY OR CREMATORY Highland	
				23d. LOCATION (City, town, or county) (State) Kansas City Missouri	

24. FUNERAL DIRECTOR Watkins Bros. 15th & Benton		25. DATE RECD. BY LOCAL REG. 4-2-59		26. REGISTRAR'S SIGNATURE Irene Marshall	
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(Licensed Embalmer's Statement on Reverse Side)

Starks J. Williams USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *Dwight R. Williams*

Licensed Embalmer No. *4500*
P. O. Address *18th St. Detroit*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.