

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018021

FILED JUN 9 1959 Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 2137 Registrar's No. 2137

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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, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If deceased in hospital or institution) <i>Frankwood Hosp.</i> 2700 TRACY		d. STREET ADDRESS (If outside, give location) 5808 WOODLAND AVE	
Length of stay in lb <i>50 yrs.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) WILLIAM CLARK WILKIN			4. DATE OF DEATH 4.25.59		
First Middle Last			Month Day Year		

5. SEX MALE	6. COLOR OR RACE WHITE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 22, 1874	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CIVIL SER.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) DEL ROY, OHIO	12. CITIZEN OF WHAT COUNTRY? US A
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13a. FATHER'S NAME THOMAS E. WILKIN	13b. MOTHER'S MAIDEN NAME JANE WOOD	14. NAME OF HUSBAND OR WIFE FRONA WILKIN
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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. none	17. INFORMANT Address MRS FRONA WILKIN 5808 WOODLAND K. C. MO
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Myocardial insufficiency</i> DUE TO (c) <i>Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>2 yr.</i> <i>5 yr +</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4221		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <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 <i>Dec 1958</i> to <i>Apr 5 1959</i> and last saw ^{her} him alive on <i>25 April 59</i> Death occurred at <i>25 April 59 4:00 p</i> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>W. W. Gist</i>	22b. ADDRESS <i>330 W 47th Chas</i>	22c. DATE SIGNED <i>26 Apr 59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4 28 59	23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH	23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.
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24. FUNERAL DIRECTOR ADDRESS <i>D W Newcome's Sons Mo. H.C.</i>	25. DATE RECD. BY LOCAL REG. <i>4-28-59</i>	26. REGISTRAR'S SIGNATURE <i>Reva Marshall</i>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

W. W. Gist



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 *Chester K Brown*

Licensed Embalmer No. *4931*

P. O. Address *K P M*

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.