

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021779

STATE FILE NUMBER

FILED JUN 24 1959

Registration District No. 149 Primary Registration District No. 002

Registrar's No. 2781

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Worth	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Grant City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V. A. Hospital		Length of stay in 1b 4 days	d. STREET ADDRESS (If outside, give location) 1130 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Emmett Middle B Last Wilson			4. DATE OF DEATH Month 6th Day 7th Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-97
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier		10b. KIND OF BUSINESS OR INDUSTRY Postal Employee	9. AGE (In years last birthday) 62 yrs IF UNDER 24 HRS Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Denver, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Ione K. Wilson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never, unknown) (If yes, give year or dates of service) Yes 9-17-18 to 12-9-18		16. SOCIAL SECURITY NO. 496 44 5615	17. INFORMANT Address V.A. Hospital, Kansas City, 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) Infarcted small bowel, ascending colon DUE TO (b) Shock, clinical DUE TO (c) Atherosclerotic aneurysm, abdominal aorta PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Old posterior septal myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH
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
21. I attended the deceased from June 3, 1959 to June 7, 1959 at Worth, Missouri Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE A. J. Williams (Degree or title)		22b. ADDRESS V.A. Hospital, Kansas City, Mo	22c. DATE SIGNED 6-7-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 6-7-59	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Grant City, Mo.
24. FUNERAL DIRECTOR Andrew Martens, Grant City, Mo		25. DATE RECD. BY LOCAL REG. 6-7-59	26. REGISTRAR'S SIGNATURE Melva Marshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUN 24 1959

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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 *John R. Didd*
Licensed Embalmer No. *45*
P. O. Address *Manassas, Ct*

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.