

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 23 1960

5615-60-042343
STATE FILE NUMBER

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

INDEXED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY JACKSON	a. STATE Missouri		b. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City	Length of stay in 1b 20 yrs	c. CITY OR TOWN Kansas City	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2425 Hardesty	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First WALTER	Middle Charles	Last WILT	4. DATE OF DEATH	Month 11	Day 7	Year 60
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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 5-10-98	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY STEEL Mill	11. BIRTHPLACE (City and state or country) LAKE City Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME John Wilt	13b. MOTHER'S MAIDEN NAME CARRIE CONNARD	14. NAME OF HUSBAND OR WIFE EUNICE Wilt
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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) WW I	16. SOCIAL SECURITY NO. 487-05-4595	17. INFORMANT EUNICE Wilt	Address 2425 Hardesty Kc 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:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) PONTINE HEMORRHAGE	12 hr
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) ARTERIO SCLEROSIS GENL-	8 YR.
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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 6 Nov. 1960 to 7 Nov. 1960 and last saw him alive on 6 Nov. 1960
Death occurred at 6:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. Wakefield M.D.	22b. ADDRESS 1103 Grand K. C. Mo.	22c. DATE SIGNED 11-7-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-9-1960	23c. NAME OF CEMETERY OR CREMATORY Floral Hills	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR Floral Hills Memorial Chapel Inc	ADDRESS Kc Mo	25. DATE RECD. BY LOCAL REG. 11-7-60	26. REGISTRAR'S SIGNATURE H. S. Dwyer
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. Wakefield

NOV 30 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Forrest D. Callenau

Licensed Embalmer No. 4714

P. O. Address K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to sign 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.