

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-009248
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1327

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b 30 Yrs | c. CITY OR TOWN Kansas City |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Dr. Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1918 Laurel |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle P Last WILSON | | 4. DATE OF DEATH Month 3 Day 13 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10 17 76 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Printer | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (last birthday) 84 |
| 11. BIRTHPLACE (City and state or country) Joplin, Missouri | | 12. CITIZEN OF WHAT COUNTRY U. S. A | |
| 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Eva B. Wilson |
| 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 Mrs. Ruby Miller 1918 Laurel | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive Heart Failure | | | INTERVAL BETWEEN ONSET AND DEATH 10 hours |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Heart Disease | | | Unknown |
| DUE TO (c) Generalized atherosclerosis | | | Unknown |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Left Hemiplegia due cerebral thrombosis | | | 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 |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) | | | |
| 20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____ Month, Day, Year _____ | | | |
| 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 |
| 21. I attended the deceased from 3-6-61 to 3-13-61 and last saw him alive on 3-12-61 Death occurred at 6:00 A m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) A. De Shong M.D. | | 22b. ADDRESS 2425 Independence Blvd KCMo | 22c. DATE SIGNED 3-14-61 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3-15-1961 | 23c. NAME OF CEMETERY OR CREMATORY Floral Hills | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri |
| 24. FUNERAL DIRECTOR ADDRESS Floral Hills Mem. Chapels, Inc | | 25. DATE RECD. BY LOCAL REG. 3.14.61 | 26. REGISTRAR'S SIGNATURE Ruth Long |

Embalmer's License

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. Sidono*
Licensed Embalmer No. 4531
P. O. Address Kansas City

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.