

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2827-61-021536
STATE FILE NUMBER

AMENDED

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

FILED JUN 28 1961

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) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 1004		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3229 Benton		d. STREET ADDRESS (If outside, give location) 3229 Benton	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First GUSSIE Middle R. Last WILSON			4. DATE OF DEATH Month June Day 5 Year 1961			
--	--	--	---	--	--	--

5. SEX Female	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 9-22-79	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
----------------------	-------------------------------	---	---------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Lenzburg, Illinois	12. CITIZEN OF WHAT COUNTRY USA
--	---	--	--

13a. FATHER'S NAME Godfried Kaegel	13b. MOTHER'S MAIDEN NAME Hanna Kruger	14. NAME OF HUSBAND OR WIFE Andrew Wilson - deceased
---	---	---

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 Pre-arranged papers signed by deceased
--	----------------------------------	---

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) Cardiac insufficiency	DUE TO (b) arteriosclerotic heart disease	48 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) generalized arteriosclerosis	10 years +
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

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 _____ a.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 **7-30-49** to **6-5-61** and last saw her ^{her} ~~last~~ alive on **6-2-61**
Death occurred at **8:00 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Herbert Shuey (Degree or title) M.D.	22b. ADDRESS 3903 Brooklyn K.C., Mo.	22c. DATE SIGNED 6-5-61
---	---	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-7-61-	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
---	--------------------------	--	--

24. FUNERAL DIRECTOR Melody-McGilley-Eylar--1800 E. Linwood	25. DATE RECD. BY LOCAL REG. 6-6-61	26. REGISTRAR'S SIGNATURE Ruth Long
--	--	--

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF **Herbert Shuey**

Dr. Herbert S
3903 Brooklyn

WA 4-6493 -

will be in at 2:30p

BRING BACK

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

James E. Backlema

Licensed Embalmer No. 4573

P. O. Address HC MD

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.