

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2843 - 61-021538

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. _____

AMENDED

FILED JUN 28 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF
Arnold V. Arms

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 6 yrs.		c. CITY OR TOWN Kansas 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 5050 Oak Street		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5050 Oak Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle JOSEPHINE Last WILSON			4. DATE OF DEATH Month June Day 7 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 2-20-1878	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Lathrop, Missouri	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Rueben Barrett		13b. MOTHER'S MAIDEN NAME Sarah E. Kelsey	
14. NAME OF HUSBAND OR WIFE Henry H. 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. None	
17. INFORMANT Mrs. Lester L. Morgan		Address 117 E. 65th			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis					INTERVAL BETWEEN ONSET AND DEATH 10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) Cerebral arteriosclerosis -
					Days
DUE TO (c) Generalized arteriosclerosis					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 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.)	
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 <u>4-25-61</u> to <u>6-7-61</u> and last saw her alive on <u>6-6-61</u> Death occurred at <u>Kansas City Mo GA</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Arnold V. Arms M.D.			22b. ADDRESS 4635 Wyandotte R. City, Mo		22c. DATE SIGNED 6-7-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 6-9-61	23c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR Freeman Mortuary		ADDRESS		25. DATE RECD. BY LOCAL REG. 6-7-61	26. REGISTRAR'S SIGNATURE Ruth Long

STATEMENT BY LICENSED EMBALMER

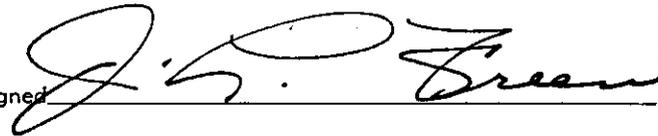
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 2939

P. O. Address F. O. 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.