

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-000456

STATE FILE NUMBER

042

1000

60

Registration District No.

Primary Registration District No.

Registrar's No.

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 23 1963

VS 300  
Rev. 4/59  
15117  
2 3228  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

G.S. Waraich, M.D. AFFIDAVIT OF CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>6 weeks</b>	c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hospital #2</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1515 OAKLEY</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lester Pentis Wilson</b>			4. DATE OF DEATH Month Day Year <b>JANUARY 20 1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CROWN Ziller Co. Haclede, Mo.</b>	11. BIRTHPLACE (City and state or country) <b>USA</b>
12a. FATHER'S NAME <b>WALTER I Wilson</b>		12b. MOTHER'S MAIDEN NAME <b>IDA Gillispy</b>	14. NAME OF HUSBAND OR WIFE <b>EDNA Wilson</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>6</b>	17. INFORMANT Address <b>MRS Edna Wilson 1515 OAKLEY</b>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic brain syndrome</b>			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.	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 <b>1-19-63</b> to <b>1-20-63</b> and last saw him alive on <b>1-19-63</b>		Death occurred at <b>5:25 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>G.S. Waraich M.D.</b>		22b. ADDRESS <b>State Hospital, St. Joseph, Mo</b>	22c. DATE SIGNED <b>20 Jan 63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>1-24-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREEN LAWN</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MO</b>
24. FUNERAL DIRECTOR ADDRESS <b>Muehlebach 6800 Troost</b>		25. DATE RECD. BY LOCAL REG. <b>Jan. 21, 1963</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Handell</b>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

JAN 25 1963

1112  
2328

Permit issued 1/20/63

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 Robert L. Landes

Licensed Embalmer No. 5103

P. O. Address K. E. Mo.

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.