

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9582
Registrar's No. 991

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: Research Hospital
(d) Length of stay: In hospital or institution 6 hrs.
In this community _____ years, months or days

3. (a) PRINT FULL NAME Babe Wasson

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex Boy 0 5. Color or race white 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 2, 1941

8. AGE: Years _____ Months _____ Days _____ If less than one day 6 hr. _____ min.

9. Birthplace Kansas City Missouri

10. Usual occupation New Idea

11. Industry or business _____

12. Name William David Wasson

13. Birthplace Gentry Arkansas

14. Maiden name Mary Lucile Mead

15. Birthplace Bremen Ohio

16. (a) Informant Research Hospital

(b) Address 23rd & Holmes St. K.C. Mo.

17. (a) Cremation (b) Date thereof Feb 2, 1941

(c) Place: burial or cremation Research Hospital

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) New 10 1941 (b) M. M. Crowe

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 3000 Tracy
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2
year 1941 hour 8 minute 10 A. M.

21. I hereby certify that I attended the deceased from Feb. 2, 1941, to Feb. 2, 1941, that I last saw him alive on Feb. 2, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Atalactasis

Due to Premature Separation of placenta

Due to _____

Other conditions _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Don Carlo Grogan (M. D. or other)

Address 717 Professional Bldg Date signed 2/11/41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

48
308

48
200

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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 this body is not embalmed, above space should be left blank.