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S. No. 2
OM-2.43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 2921

FILED JUL 13 1943
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K. C. T. B. Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs. 9 mo.
(Specify whether years, months or days)

In this community 4 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 2225 1/2 Holmes
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George Wilson

3. (b) If veteran, name war no

3. (c) Social Security No. 492-18-8422

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced, widower 2 divorced, widower

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased Aug. 19, 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>9</u>	<u>22</u>	hr. _____ min.

9. Birthplace Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation K. C. T. B. Hosp.

11. Industry or business kitchen orderly

MOTHER FATHER { 12. Name James Wilson

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant K. C. T. B. Hosp. Records

(b) Address Leeds, Mo.

17. (a) burial (b) Date thereof 6-30-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leeds

18. (a) Signature of funeral director Wm. Lohmeyer

(b) Address City Mortician

19. (a) 6-30-43 (b) J. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 11
year 1943 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from AUG.
24, 19 30 June 11, 19 43

that I last saw him alive on June 11, 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death _____

pulmonary tuberculosis

Due to _____

Due to _____

Other conditions arteriosclerotic heart
(Include pregnancy within 3 months of death)

disease

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? _____
(City or town) (County) (State)

(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 J. E. Brown (M. D. or other)

Address K. C. T. B. Hosp. Date signed 6-14-43

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, fact should be so stated above.