V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 5390

Registration District No. 149 Primary Registration District No. 1002. Registrar's No. 644

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**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution: Children's Mercy Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 4 hrs. (Specify whether years, months or days)
In this community ~~6 4 Hours~~ 14 days.

**2. USUAL RESIDENCE OF DEACESED:**

(a) State Missouri (b) County Jackson

(c) City or town 3937 Mersington, K.C. Mo.
(If outside city or town limits write "RURAL")

(d) Street No. K.C. Mo. 44
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0
If yes, name country 0

3. (a) PRINT FULL NAME Wilson, Robert Shelby

3. (b) If veteran, name war no

3. (c) Social Security No. none

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan (Month) 23, (Day) 1945 (Year)

8. AGE: Years | Months | Days 14 5 | If less than one day hr. min.

9. Birthplace Kansas City, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation infant

11. Industry or business

FATHER
12. Name Robert Shelby Wilson.
13. Birthplace K. C. Mo. (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Harriet Thrieft
15. Birthplace Atchinson (City, town, or county) Kans. (State or foreign country)

16. (a) Informant Father
(b) Address 3937 Mersington, K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-45 (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director C. H. Blackman & Son
(b) Address K. C. Mo.

19. (a) 2-8-45 (Date received local registrar) (b) R. E. Brown (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 2 day 7 year 1945 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from Post Mortem, 19..; that I last saw h. alive on, 19..; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Postmortem | |
| Due to 1. Bronchopneumonia | |
| Due to 2. Dehydration | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

PHYSICIAN — Underline the cause to which death should be charged statistically.

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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? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature J. K. Jackson M.D. (M. D. or other)
Address Grand Stage Date signed 2-7

(Licensed Embalmer's Statement on Reverse Side)

## 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.**