

**FILED** AUG 14 1946  
 199

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 3290

**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:  
GENERAL HOSPITAL NO. 2  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 mo. 25 days  
(Specify whether  
 In this community 20 yrs.  
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. 1106 GARFIELD  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** CARLTON CALBERT WILSON  
 3. (b) If veteran, name war no. 3. (c) Social Security No. 486-09-6153  
 4. Sex MALE 5. Color or race NEGRO  
 6. (a) Single, widowed, married, divorced Mar.  
 6. (b) Name of husband or wife Arlene 6. (c) Age of husband or wife if alive 29 years  
 7. Birth date of deceased NOVEMBER 11, 1905  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month JULY day 26, year 1946 hour 5: minute 35 P. M.  
 21. I hereby certify that I attended the deceased from MAY 31, 1946 to JULY 26, 1946  
 that I last saw him alive on JULY 26, 1946; and that death occurred on the date and hour stated above.  
 Immediate cause of death CONSTRICTIVE PERICARDITIS  
Duration

**8. AGE:** Years Months Days If less than one day  
40 10 15  
hr. min.

Due to PERICARDIAL EFFUSION FROM HYPERTENSIVE HEART DISEASE  
 Due to \_\_\_\_\_

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation Cleaner  
 11. Industry or business Wardrobe Cleaners 4312 Main

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

**MOTHER, FATHER**  
 12. Name WESLEY & WILSON  
 13. Birthplace OKLAHOMA  
(City, town, or county) (State or foreign country)

PHYSICIAN 93 d  
 Underline the cause to which death should be charged statistically.

14. Maiden name LULA ROBB  
 15. Birthplace KENTUCKY  
(City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant MATTIE BIGHAM (Aunt)  
 (b) Address 1106 GARFIELD

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

17. (a) Burial (b) Date thereof 7-31-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Westlawyers Cem. H.C.R.

23. Signature \_\_\_\_\_  
(M. D. or other)

18. (a) Signature of funeral director Adkins, Bros.  
 (b) Address 2000 E. 12th St. Mo.  
 19. (a) 7-29-46 (b) Eeraldine Holms  
(Date received local registrar) (Registrar's signature)

Address GENERAL HOSPITAL NO. 2 Date signed 7/27/46

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

**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 A. T. Moore.....

Licensed Embalmer No. 948.....

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.**