

S. No. 2
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5-17-39
PI X47070

DEPARTMENT OF COMMERCE
BUREAU OF PUBLIC HEALTH
FILED NOV 8 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33847

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4453

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: MARY'S REST HOME - 3215 CAMPBELL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 YEARS
(Specify whether
In this community 25 YEARS
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. 3215 CAMPBELL STREET
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MRS. MINNIE MAYNE WILSON
(b) If veteran, name war NO
(c) Social Security No. NONE

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month OCTOBER, day 21ST
year 1946 hour 6 minute 45 P. M.
21. I hereby certify that I attended the deceased from about
1 year ago, to _____, 19____,
that I last saw her alive on Oct 10, 1946

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife MR. EDGART T. WILSON
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MAY 1 1868
(Month) (Day) (Year)

Immediate cause of death Phlebotomy
Due to Thrombotic infarct femoral vein
Due to Prolonged bed ridden condition due to acute arthritis
Other conditions Arthritis general
(Include pregnancy within 3 months of death)

8. AGE: Years 78 Months 5 Days 20
If less than one day _____ hr. _____ min.

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

10. Usual occupation AT HOME

11. Industry or business _____

MOTHER FATHER { 12. Name UNKNOWN M^S LAURY
13. Birthplace GALVA ILLINOIS
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN ILLINOIS
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy 100%
Underline the cause to which death should be charged statistically.

16. (a) Informant HG W. [unclear]
(b) Address 6401 Chestnut K.C. MO.

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? _____

17. (a) BURIAL (b) Date thereof OCT 23 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MT. MORIAH CEMETERY

18. (a) Signature of funeral director O. N. Newcomer, Iowa
(b) Address 1401 BRUSH CREEK BLDG.

23. Signature Hester [unclear] (M. D. or other)
Address 1109 E. [unclear] Date signed Oct 22 1946

19. (a) 10-23-46 (b) Theraldine Holmes
(Date received local registrar) (Registrar's signature)

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

Missouri Death

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 Carl Repp

Licensed Embalmer No. 23458

P. O. Address K.C. 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 this body is not embalmed, fact should be so stated above.