

No. 2
12-45
17-39
X47070

FILED JAN 13 1947

Registration District No. 149 Primary Registration District No. 1002

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 3 1/2 DAYS (Specify whether
In this community 3 days 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. 1616 LYDIA
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME INFANT WILSON

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex MALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased OCTOBER 30, 1946
(Month) (Day) (Year)

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

9. Birthplace KANSAS CITY MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation single

11. Industry or business _____

MOTHER FATHER { 12. Name AARON WILSON

13. Birthplace KANSAS CITY MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name BOBBY MEEKINS

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

16. (a) Informant BOBBY WILSON (MOTHER)

(b) Address 1616 LYDIA

17. (a) Burial (b) Date thereof 1-9-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation buried

18. (a) Signature of funeral director Wm. A. Schuyler

(b) Address City, Missouri

19. (a) 12-31-46 (b) W. Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 3,
year 1946 hour 11: minute 20 A. M.

21. I hereby certify that I attended the deceased from OCTOBER 30, 1946 to NOVEMBER 3, 1946
that I last saw him alive on NOVEMBER 3, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death INTERVENTRICULAR SEPTAL DEFECT, CEREBRAL CONGESTION AND EDEMA

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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)
Means of injury _____

23. Signature Wm. A. Schuyler (M. D. or other) M. D.

Address GENERAL HOSPITAL NO. 2 Date signed 12/31/46

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Not Embalmed

....., Registered Apprentice No.

working under my personal supervision.

Signed *Wm A Bohmeyer*

Licensed Embalmer No. *3059*

P. O. Address *15 C 710*

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.