S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 25 1947

Registration District No. 199

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 9506

Registrar's No. 1122

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:
Colonal Rest Home 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 mos (Specify whether
In this community 70 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 4439 Forest 8
(If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME William Henry Wing

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race Wh

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

6. (b) Name of husband or wife Rosamond P. Wing

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

7. Birth date of deceased Feb 25 1857
(Month) (Day) (Year)

8. AGE: 90 Years | Months 0 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace New York State 1
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business

FATHER
12. Name Henry Wing
13. Birthplace New York State 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ruth Bowen
15. Birthplace New York State 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Margaret Polk
(b) Address 4439 Forest

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 12 47
(Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Harlyn Roe
(b) Address 7406 Wornall Rd.

19. (a) 3-11-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10
year 1947 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from January 1942, 19__, to March 10, 1947
that I last saw him alive on March 9th, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	5 years
Hypertension	5 years
Due to Senility	
Due to	
Other conditions Malnutrition (Include pregnancy within 3 months of death)	2 mo

Major findings:
Of operations —
Of autopsy —

93 N

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

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 Joseph Gitelson (M. D. or other) M.D.
Address 1219 Realto Bldg Date signed 3-11-47

(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.