

FILED DEC 26 1947, 49
Registration District No. _____

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: Research Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 min.
In this community 3 min.
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay
(c) City or town Liberty
(If outside city or town limits, write "RURAL")
(d) Street No. 342 W. Kansas
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Baby Wilson

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

4. Sex male 5. Color or race w. 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 Nov 14 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 3 min. _____

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

10. Usual occupation infant

11. Industry or business _____

12. Name Allan R. Wilson

13. Birthplace Orange New Jersey
(City, town, or county) (State or foreign country)

14. Maiden name Doris Estelle Bowser

15. Birthplace Orange New Jersey
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Allan R. Wilson

(b) Address 342 West Kansas

17. (a) Cremation (b) Date thereof 12-9-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Research Hospital

18. (a) Signature of funeral director _____
(b) Address H.C. no.

19. (a) 12-9-47 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 14
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 11
14 1947 to 11-14 1947
that I last saw him alive on 11-14 1947
and that death occurred on the date and hour stated above.

Immediate cause of death hemorrhage Separation Placenta
Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1600

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature Chapman (M. D. or other) MD
Address Liberty, Mo. Date signed 11/23/47

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

MOTHER FATHER

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.