

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 734

No. 300
10-48
FILED MAR 12 1949

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City, Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City, Mo	
c. LENGTH OF STAY (in this place) 2 Years		d. STREET ADDRESS (If rural, give location) 3215 Campbell Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3215 Campbell			
3. NAME OF DECEASED (Type or Print) a. (First) Soloman b. (Middle) E. c. (Last) Wilson		4. DATE OF DEATH (Month) (Day) (Year) 2-8-1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 2-10-1865
9. AGE (In years last birthday) Months Days 83		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Painter
11. BIRTHPLACE (State or foreign country) Monroe Co Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME George Wilson		13b. MOTHER'S MAIDEN NAME Miria Unknown	
14. NAME OF HUSBAND OR WIFE Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Roy Wilson Osborn		ADDRESS Kansas	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senile Debility ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Age DUE TO (c) 4500 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arterial Sclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July , 1946, to Feb , 1949, that I last saw the deceased alive on Feb 3 , 1949, and that death occurred at 10:30am. , from the causes and of the date stated above.			
23a. SIGNATURE Gertrude Stevens (Deedee or title)		23b. ADDRESS 1103 E Armour Blvd	
23c. DATE SIGNED 2-8-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-17-49	
24c. NAME OF CEMETERY OR CREMATORY Mt Calvary		24d. LOCATION (City, town, or county) (State) Kansas City, Kansas	
DATE REC'D BY LOCAL REG. 2-16-49		REGISTRAR'S SIGNATURE Sheraldine Holmes	
25. FUNERAL DIRECTOR'S SIGNATURE France-Wornall Funeral Home		ADDRESS France-Wornall Funeral Home	

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

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Russell N France

Signed _____
Student Embalmer

Licensed Embalmer No. 4255

P. O. Address R. C. M

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.