

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 19 1949

State File No. 15782

BIRTH MO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1961

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

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		c. LENGTH OF STAY (in this place) 174m.	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		d. STREET ADDRESS (If rural, give location) 2326 Troost	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1			
3. NAME OF DECEASED a. (First) Margaret b. (Middle) Iva c. (Last) Wilson Cameron			4. DATE OF DEATH (Month) (Day) (Year) 5-3-49
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG 7 1911
9. AGE (In years last birthday) 37		10. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) OKLAHOMA	
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME CHARLEY WILSON		13b. MOTHER'S MAIDEN NAME GOTTIE KNIGHT	
14. NAME OF HUSBAND OR WIFE WM. CAMERON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT'S SIGNATURE OR NAME Wm Cameron		ADDRESS D. C. MO	
MEDICAL CERTIFICATION			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fatty metamorphosis of liver ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) alcoholism DUE TO (c)	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 3222	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.		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 April 29, 1949, to May 3, 1949; that I last saw the deceased alive on May 3, 1949, and that death occurred at 9:15P m., from the causes and on the date stated above.			
23a. SIGNATURE Wm. W. Hart (Degree or title)		23b. ADDRESS Med. Dir. Gen'l Hosp.	
23c. DATE SIGNED 5-4-49			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE MAY 5 1949	
24c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON		24d. LOCATION (City; town, or county) (State) KANSAS CITY MO	
DATE REC'D BY LOCAL REG. 5-5-49		REGISTRAR'S SIGNATURE Geraldine Holmes	
25. FUNERAL DIRECTOR'S SIGNATURE Mrs C. J. Forster		ADDRESS D. C. MO	

Mr. Taylor

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 _____

John Clark

Licensed Embalmer No. _____

4216

P. O. Address _____

R. C. 210

Signed _____
Student Embalmer

Student Embalmer

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.