

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27095

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3600

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (in this place) <u>21 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>3544 Paseo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3544 Paseo</u>			

3. NAME OF DECEASED a. (First) <u>CYRIL</u>		b. (Middle) <u>WALTER</u>		c. (Last) <u>WILSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 18 1949</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 12, 1883</u>	
9. AGE (in years last birthday) <u>65</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	

13a. FATHER'S NAME <u>Cyril Francis Wilson</u>		13b. MOTHER'S MAIDEN NAME <u>Mary E. Thomas</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie B. Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>492-14-9126</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John F. Wilson 2400 A skew</u>	

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) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>		<u>15 yrs.</u>	
		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>NONE</u>		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) _____		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 Nov. 26, 1947, to Aug. 18, 1949, that I last saw the deceased alive on Aug. 18, 1949, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <u>C. W. Mount</u> (Degree or title) _____		23b. ADDRESS <u>3836 Frost, K.C. Mo.</u>		23c. DATE SIGNED <u>8-19-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24c. NAME OF CEMETERY OR CREMATORY <u>FOREST H. II</u>		24d. LOCATION (City, town, or county) (State) <u>K. C. Mo.</u>	
24b. DATE <u>8-20-49</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Heraldine Holmes</u>		ADDRESS <u>STINE &amp; MCCLURE CO. KANSAS CITY, MO.</u>	
DATE REC'D BY LOCAL REG. <u>8-20-49</u>		REGISTRAR'S SIGNATURE _____			

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

3836 T. Marshall

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.

Student .....  
Student Embalmer

Signed

*H. Gallen*

Licensed Embalmer No. *1445*

P. O. Address. *H. C. Co.*

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.