

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13340**
1920

FILED MAY 13 1950

BIRTH NO. 21739-50 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1920

3008
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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) <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>	
c. LENGTH OF STAY (If in place) <u>10 1/2 hrs</u>		d. STREET ADDRESS (If rural, give location) <u>3217 East 6th St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Nancy</u>		b. (Middle) <u>Clare</u>	
c. (Last) <u>Wilson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 25 1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>None</u>	8. DATE OF BIRTH <u>April 24, 1950</u>
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>None</u>
12. CITIZEN OF WHAT COUNTRY? <u>0</u>			
13a. FATHER'S NAME <u>John Foster Wilson, Jr.</u>		13b. MOTHER'S MAIDEN NAME <u>Edna Rhea Stephens</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John F. Wilson, Jr. K.C. Mo.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>atelectasis</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Intofulgencia agintion of amniotic fluid.</u>			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7620	
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) (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 <u>Apr. 24, 1950</u> , to <u>Apr. 25, 1950</u> , that I last saw the deceased alive on <u>Apr. 25, 1950</u> , and that death occurred at <u>1:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Robert S. Higgins M.D.</u> (Degree or title)		23b. ADDRESS <u>411 Alameda Pl. K.C. Mo.</u>	
23c. DATE SIGNED <u>4-25-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4-25-50</u>	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Tallatin Mo.</u>	
DATE REC'D BY LOCAL REG. <u>4-25-50</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Richardson</u>		ADDRESS <u>Bunil. Home Mo.</u>	

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

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.