

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28370

State File No. _____

3542

FILED AUG 15 1952

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1001 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson <u>4</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson <u>324y</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Kirby Convalescent Home		d. STREET ADDRESS (If rural, give location) 1716 Benton	

3. NAME OF DECEASED (Type or Print) a. (First) Fannie	b. (Middle)	c. (Last) Wilson	4. DATE OF DEATH (Month) (Day) (Year) Aug- 4-1952
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5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow <u>1</u>	8. DATE OF BIRTH May-12-1864	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during week preceding the week if retired) unemployed	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Boonville, Mo <u>0</u>	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Charles Fitzchilds	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE John Wilson (Dec.)
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Cozetta E. Davis. 3020 Mersington
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Cardiac decompensation		2 1/2 hrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Mitral Insufficiency		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility		4 1/2 hrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from June 24, 1952 to August 4, 1952, that I last saw the deceased alive on Aug 4, 1952, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Thos. A. Jones MD (Degree or title)	23b. ADDRESS 1617 E 12th	23c. DATE SIGNED 8/6/52
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24a. BURIAL, CREMATION, REMOVAL Removal	24b. DATE Aug. 7-1952	24c. NAME OF CEMETERY OR CREMATORY City Cemetery	24d. LOCATION (City, town, or county) (State) Boonville, Mo.
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DATE REC'D BY LOCAL REG. 8-7-52	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. GENERAL DIRECTOR'S SIGNATURE ADDRESS West Appleton, Iowa K.C. Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

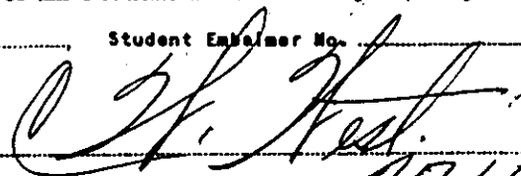
STATEMENT BY LICENSED EMBALMER

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
Student Embalmer,

Signed



Student Embalmer No. _____

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.