

FILED APR 25 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14587

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1858

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline		
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN Kansas City		c. LENGTH OF STAY (In this place) 9 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Malta Bend		0970
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital			d. STREET ADDRESS (If rural, give location) /		
3. NAME OF DECEASED (Type or Print) a. (First) FLORENCE			b. (Middle) E.	c. (Last) WILSON	4. DATE OF DEATH (Month) (Day) (Year) April 4, 1953
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH January 20, 1879	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Missouri 0		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William T. German		13b. MOTHER'S MAIDEN NAME Clarissa Ann Payne	14. NAME OF HUSBAND OR WIFE H. C. Wilson		
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. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. John Solomon, 7721 Floyd, Overland Pk. Ks.		
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) Post operative respiratory arrest & anoxemia. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Post operative perforated esophageal anastomosis DUE TO (c) Peptic ulcer of esophagus II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 5 hr 12 hr 33 days 5391
19a. DATE OF OPERATION ① 3-27-53 ② 4-3-53	19b. MAJOR FINDINGS OF OPERATION ① Peptic ulcer of esophagus ② Ruptured esophageal anastomosis			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (i.e., 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 3-21-53, 1953, to April 4, 1953, that I last saw the deceased alive on April 4, 1953, and that death occurred at 12:45 A. M., from the causes and on the date stated above.					
23a. SIGNATURE William B. Cheeseman (Degree or title) William B. Cheeseman, M.D. MD			23b. ADDRESS 530 Prof. Bldg. Kansas City, Mo.		23c. DATE SIGNED April 4, 1953
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4/4/53	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Malta Bend, Missouri		
DATE REC'D BY LOCAL REG. 4-6-53	REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE, Kansas City, Mo.		

(Licensed Embellisher's Statement on Reverse Side)

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

William B. Chaceman

530 Prof. Bldg.

Vi 0887

In act 2:30

MAY 7 1954

Anastomosis

MAY

7 1954

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

F. A. Walton

Licensed Embalmer No.

2744

P. O. Address

KC Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.