

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **5135**  
**876**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

FILED MAR 15 1954

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>										
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. LENGTH OF STAY (In this place) <b>30 yrs</b>		c. CITY OR TOWN <b>Kansas City</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>605 West 50th St.</b>										
3. NAME OF DECEASED (Type or Print) <b>DR. FERNANDO</b>			a. (First) <b>I.</b>		b. (Middle) <b>WILSON</b>		c. (Last) <b>WILSON</b>							
4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 23, 1954</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>July 3, 1894</b>						
9. AGE (In years last birthday) <b>59</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Clay Center, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
13a. FATHER'S NAME <b>William Wilson</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Dr. Hester J. Wilson</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>W.W. # I &amp; II</b>			17. INFORMANT'S SIGNATURE OR NAME <b>Dr. H.J. Wilson</b>			ADDRESS <b>605 W. 50th, K.C. MO.</b>					
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Neurocystic, with peritonitis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>40 hrs.</b>						
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Acarysion, dissecting, abd. aorta</b>				<b>16 mos.</b>						
				DUE TO (c) <b>Arteriosclerosis</b>				<b>10 yrs.</b>						
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Myocardial Fibrosis</b>				<b>8 yrs.</b>						
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) (Minute)			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>2/21</u> , 19 <u>54</u> , to <u>2/23</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>54</u> , and that death occurred at <u>6:40 a.</u> m., from the causes and on the date stated above.														
23a. SIGNATURE <b>P.L./Byers</b>						(Degree or title) <b>M.D.</b>			23b. ADDRESS <b>4635 Wyandotte, K.C. 12, Mo</b>			23c. DATE SIGNED <b>2/24/54</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			24b. DATE <b>2-25-54</b>			24c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Crematory</b>			24d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>					
DATE REC'D BY LOCAL REG. <b>2-25-54</b>			REGISTRAR'S SIGNATURE <b>Heraldine Smith</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>STINE &amp; McCLURE UND. CO.</b>			ADDRESS <b>K.C. MO.</b>					

(Licensed Embalmer's Statement on Reverse Side)

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

Rev. Phil Brown  
4635 W. Grand St.  
J. 5663

1145.0 12:30 off  
APR 12 1963

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.....  
Signature of Student Embalmer

Signed Gerald A. Burger

Licensed Embalmer No. 479

P. O. Address K. E. M.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.