

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

300  
1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAR 1 1957

STANDARD CERTIFICATE OF DEATH

5191  
STATE FILE NUMBER

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 11

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, give TOWNSHIP only) OR TOWN <b>Grandview</b>		c. CITY OR TOWN <b>Grandview</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Food Lane Road</b>		Length of stay in 1b <b>32 Years</b>	
		d. STREET ADDRESS <b>Food Lane Road</b>	

3. NAME OF DECEASED (Type or print) <b>CLARENCE ARTHUR WILSON</b>			4. DATE OF DEATH <b>February 14, 1957</b>		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>August 28, 1878</b>		
9. AGE (In years last birthday) <b>78</b>			10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Manager Sheridan Coal Company</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
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13. FATHER'S NAME <b>John Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ellen Artman</b>	
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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) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ruth F. Wilson (Wife)</b>		Address <b>Home</b>	
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b>			INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerosis a progressive</b>					
DUE TO (c) <b>occlusion of basilar artery</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	

21. I attended the deceased from 1-22-57 to 2-14-57 and last saw her/him alive on 2-13-57  
Death occurred at approx 10:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>H. L. Ketterman M.D.</b>		(Degree or title)		22b. ADDRESS <b>Hickman Mills, Mo</b>		22c. DATE SIGNED <b>2-15-57</b>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/16/1957</b>		23c. NAME OF CEMETERY <b>Mt. Washington</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>	
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24. FUNERAL DIRECTOR <b>Stine &amp; McClure - Kansas City, Mo.</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>2-15-57</b>		26. REGISTRAR'S SIGNATURE <b>Sterling Goddard</b>	
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4780

FEB 28 1957

5 P.M.

MISSOURI EMBALMERS ASSOCIATION DR

MAY 13 1957

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 *Eugene L. Harrison*

Licensed Embalmer No. 46

P. O. Address *Lawrence City, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.