

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-001570

STATE FILE NUMBER

128

FILED JAN 21 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's

300  
-57

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, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>		Length of stay in lb <u>60 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>2461 Woodland</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>WESLEY</u> Last <u>WESLEY</u>			4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>59</u>		
---	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-1896</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>11</u> Min. <u>19</u>
--------------------	---------------------------	---	-----------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Mound City, Kans.</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
--	---	--	---

13a. FATHER'S NAME <u>Mark Wesley</u>	13b. MOTHER'S MAIDEN NAME <u>Wade</u>	14. NAME OF HUSBAND OR WIFE <u>Clara Wesley</u>
--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Ethel McClallen - 2526 Green</u> Address
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho-pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture Right hip - fall at home 12-21-58</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.) <u>fall at home</u>
---	---

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>at home</u>	20f. CITY, TOWN, OR LOCATION <u>24th &amp; Cherry</u>	COUNTY _____ STATE _____
---	--	--	--------------------------

21. I attended the deceased from <u>12-25-58</u> to <u>1-6-59</u> and last saw <sup>her</sup> him alive on <u>1-6-59</u> Death occurred at <u>8:55 A M</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>Abraham Gelperin</u>	22b. ADDRESS <u>24th &amp; Cherry</u>	22c. DATE SIGNED <u>1-6-59</u>
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-12-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grain</u>	23d. LOCATION (City, town, or county) (State) <u>K C Mo.</u>
--	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>Watkins Bros. 18th &amp; Beaten</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>1-8-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>
--	---------------	---	---

All diseases in Part I must be causally related.

Abraham Gelperin M.D. MAY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ernest A. Watkins* .....

Licensed Embalmer No. *4500* .....

P. O. Address *184 V Benton* .....

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.