

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018032

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1002 STATE FILE NUMBER 2166 Registrar's No. 2166

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1508 E. 31st.		d. STREET ADDRESS (If outside, give location) 1508 E. 31st.	
3. NAME OF DECEASED (Type or print) First Norma Middle Jean Last Wilson		4. DATE OF DEATH Month 5 Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1940
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Co. N. West Mert. Ins.	11. BIRTHPLACE (City and state or country) Lowry City, Mo.
13a. FATHER'S NAME Norman Wilson		13b. MOTHER'S MAIDEN NAME Winefred Wilson	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address Norman Wilson, 2828 Harrison	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Head			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 981X			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Was shot in head	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. 5-16-59			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
		20f. CITY, TOWN, OR LOCATION Brunswick, Jackson COUNTY Jackson STATE Mo	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. C. G. Kealhofer, Jr. Deputy Coroner		22b. ADDRESS 6627 Pleasant St. S.W.	
22c. DATE SIGNED 5-17-59			
23a. BURIAL - CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-20-1959	
23c. NAME OF CEMETERY OR CREMATORY Deepwater, Missouri		23d. LOCATION (City, town, or county) (State) Deepwater, Missouri	
24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar Funeral Home Woodland-Linwood		25. DATE RECD. BY LOCAL REG. 5-18-59	
26. REGISTRAR'S SIGNATURE Neva Marshall			

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE ALL DISCREPANCIES IN PART I MUST BE CAUSALLY RELATED

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 *George A. Jackson*

Licensed Embalmer No. *5059*

P. O. Address *K.C.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.