URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS OCT 14 1960

-60-035124
STATE FILE NUMBER

ENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5010

1. PLACE OF DEATH a. COUNTY Jackson b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in 1b: 1 yr. c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Marys Hospital — Inside Limits Yes # No ☐	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson c. CITY OR TOWN Kansas City — Inside Limits Yes # No ☐ d. STREET ADDRESS (If outside, give location) 301 W. Armour — Reside on Farm Yes ☐ No #

3. NAME OF DECEASED (Type or print): First Ruth; Middle F.; Last Wilson

4. DATE OF DEATH: Month Oct.; Day 4; Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed # Divorced ☐

8. DATE OF BIRTH: Jan. 3, 1881

9. AGE (last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bulletin Employment Service

10b. KIND OF BUSINESS OR INDUSTRY: 35 yrs

11. BIRTHPLACE (City and state or country): Ranger Tex.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Jacob Frazier

13b. MOTHER'S MAIDEN NAME: Emma McMullen

14. NAME OF HUSBAND OR WIFE: Clarence A. 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.: 497-36-7111

17. INFORMANT: Mrs. Roy L. Wilson — Address: 301 W. Armour

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral vascular hemmhage	3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebral artriosclerosis	10+years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 Sept 1960, to 4 Oct 1960 and last saw her him alive on 4 October 1960

Death occurred at 1:05 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Warren F. Wilhelm, M.D.

22b. ADDRESS: Prof. Bldg KC, Mo

22c. DATE SIGNED: 10/5/60

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 10/6/60

23c. NAME OF CEMETERY OR CREMATORY: Mt Washington

23d. LOCATION (City, town, or county) (State): Kansas City Mo.

24. FUNERAL DIRECTOR: Stine & McClure — ADDRESS: K.C. Mo.

25. DATE RECD. BY LOCAL REG.: 10-5-60

26. REGISTRAR'S SIGNATURE: H. L. Dwyer

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Warren F. Wilhelm MEDICAL CERTIFICATION DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Joe B. Yoc

Signature of Student Embalmer

Licensed Embalmer No. 41

P. O. Address K. C.

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