

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-039313

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 124

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 28 1963

VS 300
Rev. 4/59

1 6001

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		c. CITY OR TOWN <u>Excelsior Springs</u>	
Length of stay in 7b <u>18 months</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Spa-View Rest Home</u>		d. STREET ADDRESS (If outside, give location) <u>505 Grand</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>C.</u> Last <u>Wilson</u>			4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/24/1890</u>
9. AGE (last birthday) <u>73</u>		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) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V.A. Hospital</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Robert S. Wilson</u>	
13b. MOTHER'S MAIDEN NAME <u>Ida Melvin</u>		14. NAME OF HUSBAND OR WIFE <u>Inez See</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. I</u>		16. SOCIAL SECURITY NO. <u>38</u>	
17. INFORMANT <u>Mrs Inez Wilson, Excelsior Springs, Mo</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per certificate) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Insufficiency</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Stroke hemorrhages 7845</u>			<u>1 month.</u>
DUE TO (c) <u>Arteriosclerosis due to Multiple Central hemorrhages 3 years</u>			<u>3 years</u>
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 _____ a.m. _____ p.m.	Month, Day, Year _____		
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 <u>Aug 1960</u> to <u>Oct 1963</u> and last saw her/him alive on <u>Oct 13, 1963</u> Death occurred at <u>2:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James R. Allan, MD</u>		22b. ADDRESS <u>Excelsior Springs, Mo.</u>	22c. DATE SIGNED <u>10-14-63.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/16/ 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>	23d. LOCATION (City, town, or county) <u>Excelsior Springs, Mo</u>
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>10-14-63</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>

USE BLACK INK OR TYPEWRITER RIBBON

10-14-63

OCT 29 1963

NOV 19 1963

NOV 6 1963

Burial Permit issued 10-14-63 E.J.H.

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 Louise Jarman

Licensed Embalmer No. 4589
P. O. Address Excelsior Springs, Mo.

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.