WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Howell

Township: Benton
or
Village: ~~Bly~~
or
City: ____ (NO. ____ St.: ____ Ward)

Registration District No.: 386

Primary Registration District No.: 5538

File No.: 10082

Registered No.: ____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Robert E. Wilcox

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

DATE OF BIRTH: Sept (Month) 11 (Day), 1840 (Year)

AGE: 75 yrs. 6 mos. 6 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): X

BIRTHPLACE (City or town, State or foreign country): Mississippi Co, Mo.

PARENTS
NAME OF FATHER: Josephus Wilcox
BIRTHPLACE OF FATHER (City or town, State or foreign country): Unknown
MAIDEN NAME OF MOTHER: Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. L. Wilcox
(ADDRESS) Bly, Mo.

Filed Mch 27, 1916 Bert Wellington
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mch (Month) 17 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 10, 1916, to Mch 17, 1916, that I last saw ~~him~~ alive on Mch 17, 1916, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Consumption pulmonary

23A

(Duration) 1 yrs. 3 mos. ____ ds.

Contributory (SECONDARY): Unknown
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Dr W. G. Wilcox M. D.
Mch 17, 1916 (Address) Bakersfield Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death 25 yrs. X mos. X ds. In the State 30 yrs. X mos. X ds.
Where was disease contracted if not at place of death? Supposed at place of death
Former or usual residence: Ark

PLACE OF BURIAL OR REMOVAL: Bly Mo
DATE OF BURIAL: Mch 18, 1916
UNDERTAKER: S. J. Hon
ADDRESS: Bly Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191...., that I last saw h..... alive on ....., 191...., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental; Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS

CAUSE OF DEATH