

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

Do not use this space.

24650  
3062

1. PLACE OF DEATH  
 County Jackson Registration District No. \_\_\_\_\_  
 Township Law Primary Registration District No. \_\_\_\_\_  
 City Kansas City Mo 2929 Main St. Willows

2. FULL NAME Lawrence Wilcox  
 (a) Residence. No. 2929 Main St, Willows 3ward  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred — yrs. - 1 mos. 23 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 13 1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
1 23

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Chief  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Kansas City  
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Unknown

12. MAIDEN NAME OF MOTHER Elizabeth Wilcox

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Missouri

14. INFORMANT Alvin R. N  
 (Address) 2929 Main St

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 6 1929

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to July 6, 1929 that I last saw him alive on July 6, 1929, and that death occurred, on the date stated above, at 12:45 a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
pyloric spasms  
109 A  
11 1/2 (duration) — yrs. - 1 mos. 23 ds.

CONTRIBUTORY (SECONDARY) franco-pneumonia  
 (duration) — yrs. — mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED 100 W  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? none  
 (Signed) H. Dwyer, M. D.  
7-6, 1929 (Address) 214 Med. Arts Bldg

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maple Hill DATE OF BURIAL 7-26 1929

20. UNDERTAKER Oxley Funeral Home ADDRESS 800 Linwood

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

15. FILED 7-12-29 M. M. Crown REGISTRAR

