

NOV 15 1938

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

35089  
Do not use this space.

1. PLACE OF DEATH

(a) County Boone Registration District No. 71  
(b) Township Cedar Primary Registration District No. 7-040 Registered No. 22  
(c) City \_\_\_\_\_ (d) Street No. 510A St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Elizabeth Gilpin Wilcox

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 20/1938 1938

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Orvis Wilcox

22. I HEREBY CERTIFY, That I attended deceased from Oct 17 1938 to Oct 20 1938

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 7/1860

I last saw her alive on Oct 20 1938 Death is said to have occurred on the date stated above, at 7:30p m.

7. AGE YEARS 78 MONTHS 0 DAYS 13 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Cerebral Lumberage  
Date of onset \_\_\_\_\_  
Other contributory causes of importance: f 2nd

12. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY) 0

FATHER 13. NAME Thomas Dozier 0

14. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY) 0

MOTHER 15. MAIDEN NAME Nettie Strode

16. BIRTHPLACE (CITY OR TOWN) Missouri (STATE OR COUNTRY)

17. INFORMANT Ida Dozier (ADDRESS) Lincoln Nebraska

18. BURIAL, CREMATION, OR REMOVAL PLACE Salem DATE Oct. 22/1938

19. FUNERAL DIRECTOR (NAME) Ashland Untd. Co. (ADDRESS) Ashland Missouri

20. FILED 7009 1938 Francis Nichols Local Registrar

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Clinical as there an autopsy? No

23. If death was due to external cause (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify \_\_\_\_\_  
(Signed) W B Fryar M. D.  
(Address) Ashland Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state

**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,

Wm. C. Burnett

, or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*Wm C Burnett*

Licensed Embalmer No. 3564

P. O. Address Ashland Missouri;

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

35-089  
Do not use this space.

1. PLACE OF DEATH

(a) County Boone Registration District No. 71  
(b) Township Cedar Primary Registration District No. 5110A Registered No. ....  
(c) City ..... (d) Street No. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Elizabeth Gilpin Wilcox  
(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 20, 1938

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

22. I HEREBY CERTIFY, That I attended deceased from

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

19... to ... 19...

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 78 0 13

I last saw h... alive on ... 19... Death is said to have occurred on the date stated above, at ... m.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife  
10. Date deceased last worked at this occupation (month and year) .....  
11. Total time (years) spent in this occupation.....

The principal cause of death and related causes of importance were as follows:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:  
Date of onset

FATHER 13. NAME

Name of operation ..... Date of .....

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

What test confirmed diagnosis? ..... Was there an autopsy? .....

MOTHER 15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19...

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Where did injury occur? (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

Manner of injury .....

19. FUNERAL DIRECTOR (ADDRESS)

Nature of injury .....

20. FILED Nov 9, 1938 Frances Nichols Local Registrar

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) H. B. Poyser, M. D.  
(Address) Ashtabud

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

S-35089