

STATE DEPARTMENT OF HEALTH - MISSOURI STATE BOARD OF HEALTH - MISSOURI STATE BOARD OF HEALTH - MISSOURI STATE BOARD OF HEALTH

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.

Registration District No. **399**

Primary Registration District No. **1002**

**1. PLACE OF DEATH:**

(a) County Texas

(b) City or town Kansas City

(c) Name of hospital or institution Hesperack  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
(years, months or days)

3. (a) PRINT FULL NAME Emogene R. Wilcox Bowman 550  
Emogene R. Wilcox Bowman

8. (b) If veteran, name war No

8. (c) Social Security No. None

4. Sex Fe

5. Color or race Wh

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Dwight Bowman

6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased April 6, 1918  
(Month) (Day) (Year)

8. AGE: Years 22 Months 1 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kansas City Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

**MOTHER**

12. Name William F. Wilcox

13. Birthplace Texas La. Iowa  
(City, town, or county) (State or foreign country)

**FATHER**

14. Maiden name Irene Murdock

15. Birthplace Kansas City Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature M. J. Wilcox

(b) Address Warrensburg Mo.

17. (a) Burial (b) Date thereof May 10, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Hill

18. (a) Signature of funeral director M. J. Wilcox

(b) Address Warrensburg Mo.

19. (a) May 9, 1940 (b) M. J. Wilcox  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Texas (b) County \_\_\_\_\_

(c) City or town Tyler  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 8  
year 1940 hour 6:30 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Apr 23, 1940,  
and that death occurred on the date and hour stated above. May 8, 1940

that I last saw her alive on May 8, 1940

Immediate cause of death Carcinoma of large intestine

Due to metastases to abdomen

Duration 6 years

Due to 46

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Colonoscopy & Intest. obs.

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Kip Robinson (M. D. or other) M.D.

Address 928 Dresser Bldg Date signed \_\_\_\_\_

**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.....

.....  
working under my personal supervision.

Registered Apprentice No.....

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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