DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34413

FILED NOV 1 [illegible]

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3929

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 906 Van Brunt 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 14 Months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 906 Van Brunt
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Mary Wilcox

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased February (Month) 16 (Day) 1862 (Year)

8. AGE: Years 78 | Months 7 | Days 25 | If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Wisconsin (State or foreign country) 1

10. Usual occupation Housewife 9

11. Industry or business Same 9

FATHER
12. Name Henry Gauers
13. Birthplace Unknown (City, town, or county) _____ (State or foreign country)

MOTHER
14. Maiden name Sarah Molten
15. Birthplace Unknown (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature Mrs. Della Davis
(b) Address 906 Van Brunt

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/40 (Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director Rose & Henderson
(b) Address 4139 E. 15th St.

19. (a) 10-11-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 10
year 1940 hour 10: 10 minute 10 P. M.

21. I hereby certify that I attended the deceased from Sept 21, 1940, to October 10, 1940
that I last saw her alive on October 10, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	
Due to No Contributory Cause known.	
Due to	
Other conditions X (Include pregnancy within 3 months of death) 130	
Major findings: Of operations X	
Of autopsy X	

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? _____ (Specify type of place)
While at work? _____ (e) Means of injury 2

23. Signature Dr Frank E. Day (M. D. or other)
Address 4316 E 9th, K.C. Mo. Date signed 10-11-40

(Licensed Embalmer's Statement on Reverse Side)

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.

X19511

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3657

P. O. Address.....

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

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