

JAN 8 1940

Registration District No. 299

Primary Registration District No. 1002

Registrar's No. 5300

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution
St. Luke's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Day
(Specify whether years, months or days)
 In this community 50 Years

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. 511 West 11th Street
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 27th
 year 1940 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from 12-26-40
 _____, 19____, to 12-27-40
 that I last saw him alive on 12-27-40
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 4 days

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy none

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

28. Signature James A. Garrison M. D. or other _____

Address 1105 Grand Ave Date signed 12-28-40

3. (a) PRINT FULL NAME Mr. Frank Marius Wilcox

3. (b) If veteran, name war None 3. (c) Social Security No. 540-03-4398

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mrs. Stella Mae Wilcox 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 7 1877
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>63</u> | <u>3</u> | <u>20</u> | hr. _____ min. _____ |

9. Birthplace Bates County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Maintenance Department

11. Industry or business Ford Motor Company

12. Name Erastus Wilcox

18. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Rosalie Sellers

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

16. (a) Informant's own signature Mr. E. Wilcox
 (b) Address 31 West 73rd Street Tennessee

17. (a) Burial (b) Date thereof Dec. 30, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (c) Signature of funeral director W. H. McCaskey

(b) Address 1401 Brush Creek Blvd

19. (a) 12-30-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

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.

V12200

4021

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. 4043
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.