

REG SEP 12 1941

Primary Registration District No. 1002

Registrar's No. 3149

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: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
(Specify whether
In this community 13 Yrs 0 (Specify whether
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. 3231 Prospect
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Benjamin H. Wilcox

3. (b) If veteran, name war _____ 3. (c) Social Security No. 487-12-2054

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

6. (b) Name of husband or wife Addie Wilcox 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased Sept. 1st
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>67</u>	<u>11</u>	<u>18</u>	hr. _____ min.

9. Birthplace New York
(City, town, or county) (State or foreign country)

10. Usual occupation Mechanic

11. Industry or business _____

12. Name Benjamin H. Wilcox

13. Birthplace Danville, N.Y.
(City, town, or county) (State or foreign country)

14. Maiden name Sophronia Canfield

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

16. (a) Informant Addie Wilcox Swank
(b) Address LeRoy, Kansas

17. (a) Removal (b) Date thereof 8-20-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremations _____

18. (a) Signature of funeral director LeRoy Canfield

(b) Address 32332 LeRoy, Kan.

19. (a) 8/20/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19th
year 1941 hour 7 minute 55 P. M.

21. I hereby certify that I attended the deceased from 8-15-41 to 8-19-41

that I last saw him alive on 8-19-41
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia, type 33

Due to _____

Due to _____

Other conditions (Include pregnancy within 8 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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) (Means of injury)

23. Signature Dr. R. P. Shaw (M. D. or other) D

Address Med. Dir. K.C. Gen. Hospital Do 8-20-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

103

MC

048
100

100

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..... *Blaine E. Neilest*

Licensed Embalmer No. *4075*

P. O. Address *Kansas City, Mo*

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, fact should be so stated above.