No. 2
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17-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 16 1942

Registration District No. 3149

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002.

State File No. 5706

Registrar's No. 855

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: Marty Clinic 815 McGee
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 hours (Specify whether
In this community 4 Mo. years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

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

(d) Street No. 6108 St John
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME John ~~William~~ Watts Wilcox

3. (b) If veteran, name war --

3. (c) Social Security No. --

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife --

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

7. Birth date of deceased Oct. 27, 1941 (Month) (Day) (Year)

8. AGE: Years | Months 4 | Days 4 | If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business --

MOTHER FATHER
12. Name John William Wilcox
13. Birthplace Swwet Springs, Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Goldie Fern Brown
15. Birthplace Mansfield, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant John William Wilcox
(b) Address 6108 St John

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 3-42 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director Sheil Funeral Home
(b) Address 6606 Indep. Ave. K.C. Mo.

19. (a) 3/2/42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 1
year 1942 hour 4 minute 15 P M.

21. I hereby certify that I attended the deceased from Feb. 18, 1942 to Mar. 1, 1942
that I last saw him alive on Mar 1. 1942
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Status thymus lymphaticus	1 day.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. J. Pocsik (M. D. or other) D.O.
Address 5902 St. John Date signed 3/2/42

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(Licensed Embalmer's Statement on Reverse Side)

Stake Thymus Lymphatics

Dr. Posic

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.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.