

FILED DEC 26 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41520

Registration District No. 252

Primary Registration District No. 5871

Registrar's No.

1. PLACE OF DEATH:

(a) County Howard Oregon
 (b) City or town Thomassville
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME

David Glen Wilcox3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced Infant
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 10 6 1946
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 40 Month
 (If less than one day hr. _____ min. _____)

9. Birthplace Thomassville Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Infant

11. Industry or business _____

12. Name E. G. Wilcox
 13. Birthplace Oregon Co. Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Lucille Pierce
 15. Birthplace Oregon Co. Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant E. G. Wilcox
 (b) Address Thomassville, Mo.
 17. (a) B (b) Date thereof 10-6-46
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Bethlehem Ch.

18. (a) Signature of funeral director Robertson's
 (b) Address West Plains, Mo.
 19. (a) 1-20-47 (b) mo w.c. Johnston
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Oregon
 (c) City or town Thomassville Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 6
 year 1946 hour 11 minute 4 A.M.

21. I hereby certify that I attended the deceased from 10-6 1946 to 10-6 1946
 that I last saw h _____ alive on _____ 19 _____
 and that death occurred on the date and hour stated above.

Immediate cause of death Head in Lunge
 Duration _____

Due to _____
 Due to _____

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

Major findings: 161A
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____

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 P. W. Cooper (M. D. or other) MD
 Address Thomassville Mo. Date signed 10-15-46

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(Licensed Embalmer's Statement on Reverse Side)

Cooper

RECEIVED

District Health Officer No. 5.

District File Number. 1246092

Date Filed 12-24-46

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 with the above constitutes grounds for revocation of license.)

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

Registration District No. 255

Primary Registration District No. 5875

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Thomasville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME David H Wilcox
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Oct 6 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 30 min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Jan 20 47 (b) Mrs W.C. Johnson (If to received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

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 _____

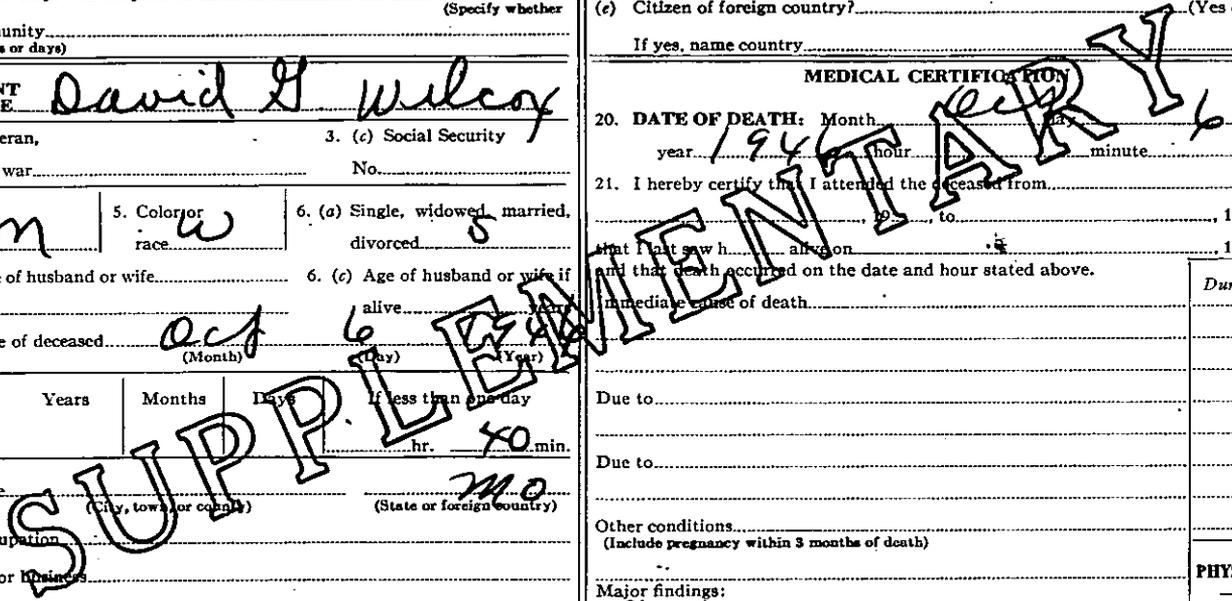
(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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



RECEIVED

District Health Officer No. 5,

District File Number 14740

Date Filed 1-31-47

41520