

S. No. 2
 DM-5-43
 v. 5-17-39
 I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **24434**
 Registrar's No. **3172**

FILED AUG 13 1947

Registration District No. 127 Primary Registration District No. 1002

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

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 MO. 16 days
(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. 2326 Summit
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Thomas Wilcox
 (b) If veteran, name war no
 (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 27
 year 1947 hour 7 minute 30 A. M.
 21. I hereby certify that I attended the deceased from
June 11 1947 to July 27 1947
 that I last saw h. im alive on July 27
 and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race Wh
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Lena 6. (c) Age of husband or wife if
 alive 55 years
 7. Birth date of deceased: June 25 1884
(Month) (Day) (Year)

Immediate cause of death Cirrhosis of liver with ruptured esophageal varices
 Duration _____

8. AGE: Years 63 Months 1 Days 2
 If less than one day hr. _____ min. _____

Due to _____
 Due to _____

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

Other conditions 12 yr
(Include pregnancy within 3 months of death)

10. Usual occupation Retail Dealer

Major findings:
 Of operations _____
 Of autopsy See above
PHYSICIAN
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____
 12. Name John C. Wilcox
 13. Birthplace Missouri
 14. Maiden name Nancy M. Sappington
 15. Birthplace Missouri

16. (a) Informant Roy C. Wilcox
 (b) Address 4444 Bell

17. (a) Burial (b) Date thereof 7-27-47
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director Quirk + Golin
 (b) Address 76 E. 9th
 19. (a) 7-28-47 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

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 Wm W. Hart (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp. Date signed 7-28-47

Dr. Keeler

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 *Howard W. Farmer*
Licensed Embalmer No. *1934*
P. O. Address... *Keeler*

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.