

FILED SEP 25 1950

STANDARD CERTIFICATE OF DEATH

State File No. 30068

No. 300
10.48

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 821

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD	
c. LENGTH OF STAY (in this place)		0396 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 619 N. CAMPBELL		d. STREET ADDRESS (If rural, give location) 619 N. CAMPBELL	

3. NAME OF DECEASED (Type or Print)	a. (First) FLORENCE	b. (Middle)	c. (Last) WILCOX	4. DATE OF DEATH (Month) (Day) (Year) SEPT. 17 1950
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUGUST 28 1877	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY IN Home	11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME WILLIS PAGENT	13b. MOTHER'S MAIDEN NAME ? McCAFFEY	14. NAME OF HUSBAND OR WIFE HARRISON WILCOX
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME TOM MORRIS	ADDRESS SPGFD. MO.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chole Nephritis		INTERVAL BETWEEN ONSET AND DEATH 2 yr.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June, 1950, to Sept 17, 1950, that I last saw the deceased alive on Sept 16, 1950, and that death occurred at 8:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Max Hibel	23b. ADDRESS MIO-0 Springfield Mo	23c. DATE SIGNED 9-17-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 9-19-50	24c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEME.	24d. LOCATION (City, town, or county) (State) SPRINGFIELD MO.
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DATE REC'D BY LOCAL REG 9-19-50	REGISTRAR'S SIGNATURE W E Handley	FUNERAL DIRECTOR'S SIGNATURE J. Klingner & Co.	ADDRESS Spfld. Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

6396
1

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Max Rhodes

Licensed Embalmer No. 4071

P. O. Address

Springfield

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.