

FILED MAY 26 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 16282

BIRTH NO. _____		REG. DIST. NO. 141		PRIMARY REG. DIST. NO. 5550		Registrar's No. 440420		
1. PLACE OF DEATH a. COUNTY <u>Howell</u> 0460				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>				
b. CITY OR TOWN <u>Caulefield</u>		c. LENGTH OF STAY (in this place) <u>70 yrs</u>		c. CITY OR TOWN <u>Caulefield, Mo</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Tom</u> b. (Middle) <u>Jasper</u> c. (Last) <u>Wilcox</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>5-31-52</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>2</u>		8. DATE OF BIRTH <u>11/6-1872</u>		
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work during most of working life, or as if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>R. E. Wilcox</u>			13b. MOTHER'S MAIDEN NAME <u>Diana Rhoads</u>			14. NAME OF HUSBAND OR WIFE <u>Martha Wilcox</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT'S SIGNATURE OR NAME <u>Gene Wilcox, N. Hollywood, Ark</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
i. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Acute dilatation of heart</u>								
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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. <u>Grand dead in home</u>						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>4343</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Beatrice Cook Roberts</u>				23b. ADDRESS <u>3 West Plains Mo</u>		23c. DATE SIGNED <u>24/Apr-52</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/2</u>		24b. DATE <u>7/2-1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Spring</u>		24d. LOCATION (City, town, or county) (State) <u>West Plains Mo</u>		
DATE REC'D BY LOCAL REG. <u>5-31-52</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook Roberts</u>		2. FUNERAL DIRECTOR'S SIGNATURE <u>Roberts</u> ADDRESS <u>West Plains Mo</u>				

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

**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 *D. D. Roberts* \_\_\_\_\_

Licensed Embalmer No. *3437* \_\_\_\_\_

P. O. Address *West Plains, 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.