

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11295**

BIRTH NO. **FILED MAY 3 1954** REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **422**

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

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Dawn - Rural</b>	
c. LENGTH OF STAY (in this place) <b>23y-5m-28d</b>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>State Hospital #2</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>JOHN</b> b. (Middle) <b>H.</b> c. (Last) <b>WILCOX</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>April 17, 1954</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) <b>Never married</b>	
8. DATE OF BIRTH <b>Not given</b>		9. AGE (In years last birthday) <b>Abt. 77</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>Lorenze Wilcox</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mary E. Wagy, Dawn, Mo.</b>	

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* (a) <b>Chronic Myocarditis</b>		DUE TO (b) <b>Arterio Sclerosis</b>			<b>1 yr.</b>
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS		<b>Mental Deficiency</b>			
Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>4/22/54</b>			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 **Jan 1, 1954** to **Apr 17, 1954**, that I last saw the deceased alive on **Apr 17, 1954**, and that death occurred at **11:30Am.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Forrest Thomas MD</b> (Degree or title)		23b. ADDRESS <b>State Hospital #2, City</b>		23c. DATE SIGNED <b>4-17-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>4-20-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>School of Osteopathy</b>	
		24d. LOCATION (City, town, or county) (State) <b>Kirkville, Mo.</b>			

DATE REC'D BY LOCAL REG. <b>Apr. 26, 1954</b>		REGISTRAR'S SIGNATURE <b>Katherine M. Allison</b> <b>485</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Victor Barry, St. Joseph, Missouri.</b>	
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**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

*Victor J. Barry*

Licensed Embalmer No. *4212*

P. O. Address *St Joseph 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.