

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006693

STATE FILE NUMBER

FILED MAR 3 1959		Registration District No. 290		Primary Registration District No.		Registrar's No. 17	
1. PLACE OF DEATH a. COUNTY <b>Pulaski</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Michigan</b> b. COUNTY <b>Branch</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fort Leonard Wood</b>				c. CITY OR TOWN <b>Coldwater</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>On road approx 1 mile from Bldg 862</b>				Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>89 Jackson Street</b>	
3. NAME OF DECEASED (Type or print) <b>James Stewart Wilcox</b>				4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		18. DATE OF BIRTH <b>November 19, 1935</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (City and state or country) <b>Quincy, Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Cecil Wilcox</b>				13b. MOTHER'S MAIDEN NAME <b>Mildred L. (unknown)</b>		14. NAME OF HUSBAND OR WIFE <b>-</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>Dec 4, 1958 to pres.</b>				16. SOCIAL SECURITY NO. <b>380-36-8742</b>		17. INFORMANT Address <b>Bernard S Wysocki, US Army Hosp, Ft Wood, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>-Respiratory-Insufficiency- Cardiorespiratory collapse</b> DUE TO (b) <b>=Lobar-Pneumonia-=bilateral= Pulmonary hemorrhage and edema</b> DUE TO (c) <b>Pneumothorax, right, spontaneous</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>520x</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>((Item 18, I(a)(b)(c) chgd by dr's advt 3-27-59--jf))</b>				
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION COUNTY STATE				
21. I <del>certify</del> the deceased <del>was</del> on <b>February 13, 1959</b> at <del>about 11:00</del> Death occurred at <b>3:45</b> pm on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>H Branch</b>			(Degree or title) <b>Capt, MC</b>		22b. ADDRESS <b>US Army Hospital Ft Leonard Wood, Missouri</b>		22c. DATE SIGNED <b>Feb 14, 1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2-15-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>XXXX Lakeview Cem</b>		23d. LOCATION (City, town, or county) <b>Quincy Michigan</b>	
24. FUNERAL DIRECTOR <b>Hedges Funeral Homes Inc</b>				ADDRESS <b>CROCKER MO</b>		25. DATE RECD. BY LOCAL REG. <b>2-15-59</b>	
26. REGISTRAR'S SIGNATURE <b>Conrad G. Anderson</b>							

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MAR 5 1959

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Clarence Moss  
Licensed Embalmer No. 4886  
P. O. Address Waynesville, N.C.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.