

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039315**

**FILED VS DEC 2 1959**

STATE FILE NUMBER

Registration District No. 65 Primary Registration District No. \_\_\_\_\_ Registrar's No. 4

EMENDED

1. PLACE OF DEATH a. COUNTY <b>CHARITON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>CHARITON</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>TRIPLETT</b>		Length of stay in 1b <b>40YRS</b>		c. CITY OR TOWN <b>TRIPLETT</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			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>CLAIR</b> Last <b>WILCOX</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>19</b> Year <b>1959</b>					
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 26, 1887</b>	9. AGE (last birthday) <b>72</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (City and state or country) <b>CARROLL Co., Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		
13a. FATHER'S NAME <b>FRANKLIN D. CLAIR</b>			13b. MOTHER'S MAIDEN NAME <b>IDA MAY GODWIN</b>			14. NAME OF HUSBAND OR WIFE <b>J.T. WILCOX</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>LEWIS C. SANDERS, CHICAGO, ILL.</b>				Address	
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>CARCINOMA (PRIMARY SITE, UTERINE CERVIX)</b>								INTERVAL BETWEEN ONSET AND DEATH <b>5YRS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>WITH METASTASIS TO STOMACH, DUODENUM</b>							
		DUE TO (c) <b>AND LIVER</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <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 attended the deceased from <b>4-7-53</b> to <b>11-19-59</b> and last saw her <b>him</b> alive on <b>11-19-59</b> Death occurred at <b>10:30 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Kenneth L Rosecrance DO</b>				22b. ADDRESS <b>TRIPLETT Mo</b>				22c. DATE SIGNED <b>11-21-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>NOV. 22, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>McCULLOUGH CEM. TRIPLETT, Mo</b>			23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR <b>WRIGHT FUNERAL HOME, BROOKFIELD, Mo</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>NOV 24 - 1959</b>		26. REGISTRAR'S SIGNATURE <b>Howie Smith</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

KENNETH L ROSECRANCE DO.

MS DEC 2 1958

MSI 11 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed Harold B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com  
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.