

REC'D MAY 18 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

14728
Do not use this space.

1. PLACE OF DEATH
 (a) County Dallas Registration District No. 247
 (b) Township Wilson Primary Registration District No. 534B
 (c) City Phillipsburg (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Susan M. Wilcox
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ♀ 4. COLOR/OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Franklin Wilcox

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-12-1854

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>84</u>	<u>5</u>	<u>21</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-3-1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1939, to 4-3, 1939
 I last saw her alive on 4-20 1939 Death is said to have occurred on the date stated above, at 11:20 AM.
 The principal cause of death and related causes of importance were as follows:

Pneumonia Bronch

Date of onset _____

Other contributory causes of importance:
Injury to leg - about 7-8 days invalid

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Delaware Co Ind

FATHER

13. NAME James R Foster

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa

MOTHER

15. MAIDEN NAME Sarah Lewis

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT S. F. Wilcox (ADDRESS) Phillipsburg Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Green Forest DATE 4-5-1939

19. FUNERAL DIRECTOR (NAME) L. B. Jones (ADDRESS) Phillipsburg Mo

20. FILED 5-10-1939 L. J. [Signature] Registrar.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) W. J. [Signature], M. D.
 (Address) Phillipsburg Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

107a

RECEIVED
District Health Officer No. 7,
District File Number 1-35-82
Date Filed 5-12-39

MA embone
218 2000 pe aster EXVCLIX

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

14728
Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 247
(b) Township Wilson Primary Registration District No. 3343 Registered No.
(c) City (d) Street No.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Susan M. Hiley

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
84 5 21

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4-3-19

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Pneumonia (Bronch) Date of onset

186 W

Other contributory causes of importance:

Injury to leg about a year ago healed

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, ~~suicide~~, or homicide? Date of injury 19.....

Where did injury occur? in home (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Fall

Nature of injury Bruised Contusion

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. J. Lindsay, M. D.

(Address) Conway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

