

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

PLACE OF DEATH

County Oregon
Township _____
or
Village Village
or
City Koshkoneong (NO. _____) St. _____ Ward _____

Registration District No. 631 File No. 35086
Primary Registration District No. 4381 Registered No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Otis Abraham Cox

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Labourer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Texas Co Mo

NAME OF FATHER John M. Cox

BIRTHPLACE OF FATHER (City or town, State or foreign country) Deut. Co. Mo.

MAIDEN NAME OF MOTHER Blauche E. Lemons

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Texas Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M. Cox
(ADDRESS) Megargel, Texas

Filed Nov-24 1910 W.C. Amerman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11 22 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 11/18, 1910, to 11/23, 1910, that I last saw him alive on 11/22, 1910, and that death occurred, on the date stated above, at 8 P.m.
The CAUSE OF DEATH* was as follows:

Pott's Disease of Spine
26
1778 (Duration) _____ yrs. _____ mos. _____ ds.

Contributory Cholangitis
(SECONDARY) (Duration) 0 yrs. 0 mos. 4 ds.

(Signed) W. E. Pless M. D.
11/23 1910 (Address) Koshkoneong Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Koshkoneong Cemetery DATE OF BURIAL Nov 24 1910

UNDERTAKER W.C. Amerman ADDRESS Koshkoneong Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



WRITE PLAINLY, WITHOUT LEADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be as full and accurate as possible. 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.

PLACE OF DEATH

County Oregon
Township _____
or
Village Kashkonong
or
City Kashkonong (No. _____) St.: _____ Ward _____

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

STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 631 File No. 35086
Primary Registration District No. 4381 Registered No. 9

FULL NAME

Celia Abraham Cox

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--|---|---|
| SEX <u>Male</u> | COLOR OR RACE <u>White</u> | SINGLE MARRIED WIDOWED OR DIVORCED (Write in words) <u>Married</u> |
| DATE OF BIRTH <u>X</u> <u>March</u> <u>17</u> , <u>1883</u> (Month) (Day) (Year) | | |
| AGE <u>X</u> <u>37</u> yrs. <u>9</u> mos. <u>5</u> ds. | | If LESS than 1 day, _____ hrs. or _____ min.? |
| OCCUPATION (a) Trade, profession, or particular kind of work <u>Labour</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| BIRTHPLACE (City or town, State or foreign country) <u>Texas Co. Mo</u> | | |
| PARENTS | NAME OF FATHER <u>John M. Coleman</u> | |
| | BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Mo</u> | |
| | MAIDEN NAME OF MOTHER <u>Blanche Demons</u> | |
| | BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Texas Co. Mo</u> | |
| THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John H. Cox</u> (ADDRESS) <u>Megarard, Texas</u> | | |
| Filed <u>Nov 24</u> 191 <u>0</u> | REGISTRAR <u>W. C. Underman</u> | |

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11 - 23, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 11/18 to 11/22, 1910, that I last saw her alive on 11/22, 1910, and that death occurred, on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Death Disease of
Cholangitis

Contributory (SECONDARY) Cholangitis
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Underman M. D.
(Address) Kashkonong Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state the Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence? _____

PLACE OF BURIAL OR REMOVAL Kashkonong Cemetery DATE OF BURIAL Nov. 24, 1910

UNDER TAKER H. C. Underman ADDRESS Kashkonong

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)