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.

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

PLACE OF DEATH

County: Gentry

Township: Cooper

or Village:

or City: Stanberry (NO. ____, ____ St.; ____ Ward)

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

Registration District No. 314 — File No. 7493

Primary Registration District No. 419 D — Registered No. 6

FULL NAME Frank Harris Hecox

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W.	Married

DATE OF BIRTH: May (Month) 1 (Day), 1858 (Year)

AGE: 56 yrs. 10 mos. 19 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Rail Road Employee
(b) General nature of industry, business, or establishment in which employed (or employer): ~~Illinois~~

BIRTHPLACE (City or town, State or foreign country): Illinois

PARENTS
- NAME OF FATHER: Carlos F. Hecox
- BIRTHPLACE OF FATHER (City or town, State or foreign country): unknown.
- MAIDEN NAME OF MOTHER: Dixon.
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): unknown.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carlos F. Hecox

(ADDRESS) St Louis Mo

Filed Mar 21 1925 Ira E. Grimes — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: March (Month) 20 (Day), 1925 (Year)

I HEREBY CERTIFY, that I attended deceased from 3/10, 1925, to 3/20, 1925 that I last saw him alive on 3/20, 1925 and that death occurred, on the date stated above, at 1130 m.

The CAUSE OF DEATH* was as follows:

Bulbular Paralysis

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Jas. A. Crockett M. D.

3/20 1925 (Address) Stanberry, 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	DATE OF BURIAL
Hood River Oregon	4/3 1925

UNDERTAKER	ADDRESS
Laton F. Phillips	Stanberry Mo

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

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1_____ (Year)

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

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

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS
- NAME OF FATHER _____
- BIRTHPLACE OF FATHER (City or town, State or foreign country) _____
- MAIDEN NAME OF MOTHER _____
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*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	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

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.