

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

Do not use this space.

20522

AUG 18 1927

1. PLACE OF DEATH

Com. Frank Registration District No. 923 File No. _____
 Township Wells Primary Registration District No. 4575 Registered No. 10
 City Franklin (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1857-02-20

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
70 4 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) None
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Franklin Mo
 (STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Thomas Cox

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Franklin Mo
 (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Rachel Adams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Franklin Mo
 (STATE OR COUNTRY) Mo

14. INFORMANT Theoressa Cox
 (Address) Franklin City Mo

15. FILED July 27 1927 John Andrews
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 24 - 1927

17. I HEREBY CERTIFY, That I attended deceased from March, 1927, to June 24, 1927 that I last saw him alive on June 23, 1927, and that death occurred, on the date stated above, at 11 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis
Chronic Muscular Dystrophy
 (duration) yrs. 6 mos. 4 da.

CONTRIBUTORY (SECONDARY) Chronic Nephritis
 (duration) yrs. 2 mos. 4 da.

18. WHERE WAS DISEASE CONTRACTED? 1-29-10
 IF NOT AT PLACE OF DEATH, STATE _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms

(Signed) J. K. Phipps, M. D.

(Address) Franklin City, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Franklin City Mo

DATE OF BURIAL 7/25 1927

20. UNDERTAKER Andrews Bros
 ADDRESS Franklin City

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.

1000