

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

Do not use this space.

32547

1. PLACE OF DEATH

County Vernon Registration District No. 176
Township Richmond Primary Registration District No. 6163
City Richmond (No.) St. Ward)

2. FULL NAME Mr. Augustus Cox

(a) Residence. No. Stoddard, Mo. 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 M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1884 9 13

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 84 9 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Jacksonville, Ills.
(STATE OR COUNTRY)

10. NAME OF FATHER Laertes Cox

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Jacksonville, Ills.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Scott

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

14. INFORMANT Mrs. John Shaw, daughter
(Address) Richmond, Mo.

15. FILED 10/14 1927 Scott O. Child
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 12th 1927

I HEREBY CERTIFY, That I attended deceased from July 7th 1927, to Oct. 12th 1927, that I last saw him alive on Oct. 12th 1927, and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute posterior uveitis with urinary suppression

CONTRIBUTORY (SECONDARY) Chronic prostatitis & cystitis
(duration) 5 yrs. 1 mos. 1 da.

18. WHERE WAS DISEASE CONTRACTED 135
IF NOT AT PLACE OF DEATH: no

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

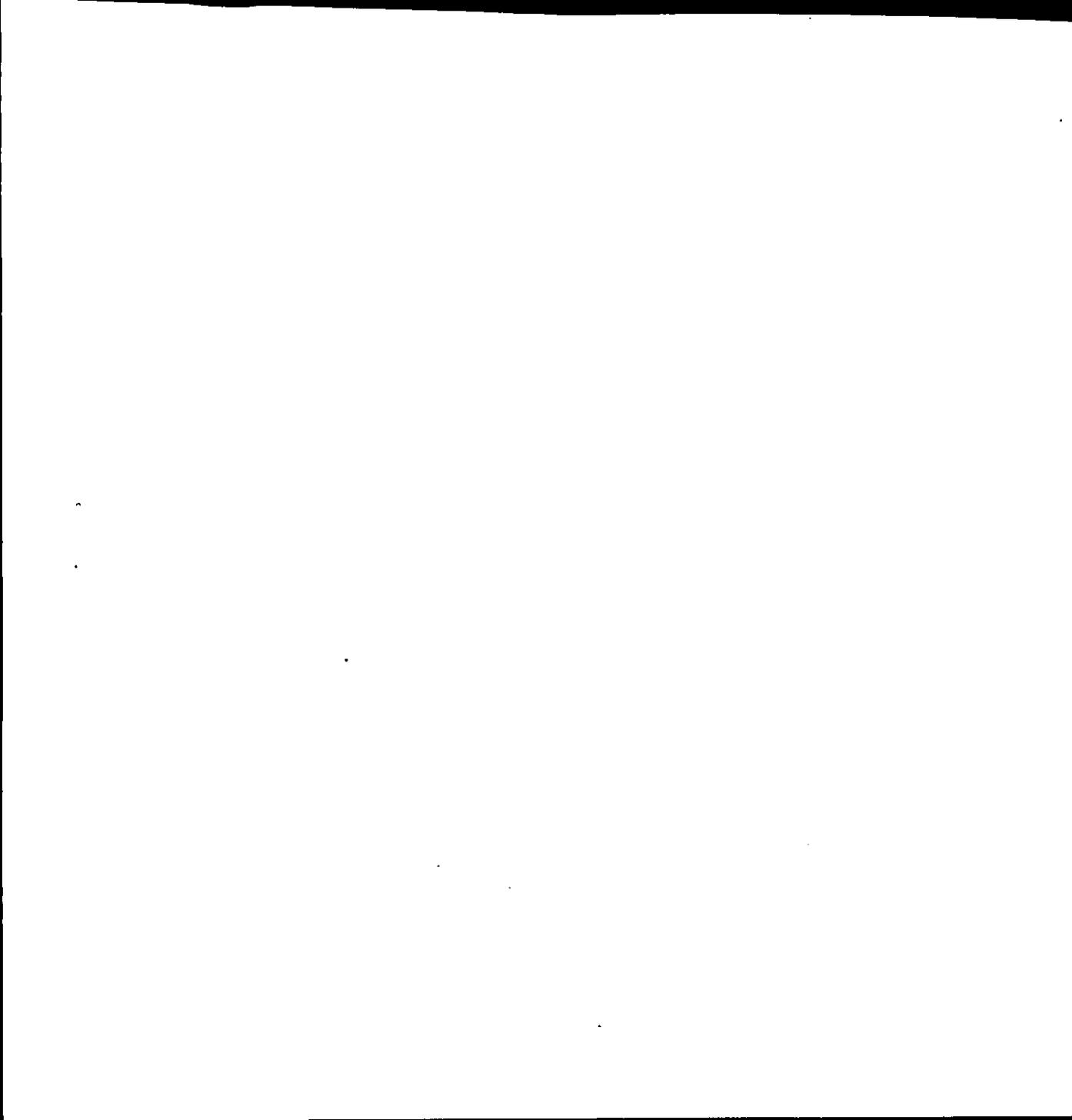
WHAT TEST CONFIRMED DIAGNOSIS? Signs & symptoms

(Signed) Scott O. Child, M. D.
, 19 (Address) Richmond, 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 St. Liberty Cem. DATE OF BURIAL 10/15th 1927

20. UNDERTAKER Konowitz ADDRESS St. Scott, Mo.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Vernon Registration District No. 876 File No. _____
 Township Richland Primary Registration District No. 6163 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Wm Augustus Cox

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 29th 1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY)

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT _____
 (Address)

15. FILED 10/14th 1927 Scott P. Child
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 12 1927

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____, that I last saw him alive on _____, 19____, 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address)

*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 DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY

S-32547