1928

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

Do not use this space.

26688

1. PLACE OF DEATH

County: Country — Registration District No.: 1431 — File No.:

Township: Country — Primary Registration District No.: 5205 — Registered No.:

City: Van Buren (No. ..... St. ..... Ward)

2. FULL NAME: Donald Samuel Fox

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 20, 1927

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4	

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): Van Buren
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: Henry Clifford Fox

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

12. MAIDEN NAME OF MOTHER: Cora Alice Ward

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

14. INFORMANT .....
(Address) .....

15. FILED ....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): August 24 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug. 21st, 1928, to Aug. 24, 1928, that I last saw him alive on Aug. 24, 1928, and that death occurred, on the date stated above, at 7 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia from Furuncle,

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 153B

(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) J. N. Cotton, M. D.

, 19 (Address) Van Buren, 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: Van Buren Cem — DATE OF BURIAL: 8-25-1928

20. UNDERTAKER: C. E. Murray — ADDRESS: Van Buren

NB. 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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Carter — Registration District No. 143 — File No.
Township Carter — Primary Registration District No. 5205 — Registered No.
City (No. , St. Ward)

2. FULL NAME Donald Samuel Fox

(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): S

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.

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)

PARENTS
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 Henry Clifford Fox
(Address)

15. FILED 8-27, 1928 Dr. J. W. Patton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 24 1928

17.
I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h 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: Van Buren, MO
DATE OF BURIAL: 8-25 1928

20. UNDERTAKER: C. E. Murray
ADDRESS: Van Buren, MO

SUPPLEMENTARY

N. B. ... information should be carefully supplied. AGE should ... EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ... tement or OCCUPATION is very important.

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

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