

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

Do not use this space.

36053

**1. PLACE OF DEATH**

County, Boone  
Township  
City, Columbia (No. ....)

Registration District No. 43  
Primary Registration District No. 3006

File No. 218  
Registered No. 73  
St. .... Ward

**2. FULL NAME**

Ms Helen Agnes Lovell Cox  
(a) Residence, No. Indiana Ave St. .... Ward.  
(Usual place of abode)  
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 - Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 27-1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
84 | 8 | 19

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed (or employer) -  
(c) Name of employer Diptych

9. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Dallas, Texas

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN, STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN, STATE OR COUNTRY) Not known

14. INFORMANT Walter R. Cox,  
(Address)

15. FILED 11.21.28 Beatrice Gibbs  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

I HEREBY CERTIFY, That I attended deceased from 11-16, 1928, to 11-16, 1928, that I last saw her alive on 11-9, 1928, and that death occurred, on the date stated above, at 9:20 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Arterio Sclerosis,

97718 Several yrs.  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 118  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH. no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? symptoms  
(Signed) W. A. Horne, M. D.  
1928 (Address) Columbia, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oakland Cemetery DATE OF BURIAL Nov 16 28

20. UNDERTAKER R. B. Baker ADDRESS Columbia Mo.

Information should be carefully supplied. "AGE" should be stated EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important.

26 1928



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Boone Registration District No. 73 File No. ....  
 Township Columbia Primary Registration District No. 3006 Registered No. 73  
 City Columbia (No. ....) St. .... Ward .....

2. FULL NAME Helen Agnes L. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED wid  
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 27 1844

7. AGE YEARS MONTHS DAYS 84 8 19  
 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 1-14, 1928 Beatrice Gustafson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 16 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 DATE OF BURIAL  
 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

N. B.—Every form 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS

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