

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

Do not use this space.

128

1. PLACE OF DEATH

County Barton Registration District No. 1017
Township Union Primary Registration District No. 0060
City Paris (No. _____) St. _____ Ward _____

File No. 1
Registered No. 1

2. FULL NAME

Marion Hamilton 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 48 yrs. mos. 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 11 - 1841

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>87</u>	<u>7</u>	<u>10</u>	

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) Springfield
(STATE OR COUNTRY) MO.

10. NAME OF FATHER William Parker Cox

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

12. MAIDEN NAME OF MOTHER Elizabeth Jessup

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

14. INFORMANT Wm. Bertold Winters
(Address) _____

15. FILED Feb 10th 1929 C. A. Gould
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan - 21st 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov - 15th 1928 to Jan - 21st 1929
that I last saw him alive on Jan 21st 1929, and that death occurred, on the date stated above, at 9:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

(duration) yrs. 2 mos. 5 ds.
CONTRIBUTORY (SECONDARY) Infirmities of age

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) W. H. Applewell, M. D.

Jan 22nd 1929 (Address) Lamar, 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 Lamar Cemetery
DATE OF BURIAL 1-23-1929

20. UNDERTAKER G. B. Beeny & Sons
ADDRESS Sheldon MO

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.

1929
00606

