

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

Do not use this space.

1. PLACE OF DEATH

County Callaway
Township Fulton
City..... (No..... St..... Ward)

Registration District No. 104
Primary Registration District No. 5153

File No. 17469
Registered No. 109

2. FULL NAME James Marcellus 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Nannie Cox</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>11/8 1855</u>		
7. AGE YEARS <u>73</u>	MONTHS <u>6</u>	DAYS <u>20</u>
IF LESS than 1 day, hrs. or min.		

8. OCCUPATION OF DECEASED Farmer
(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) Ky.
(STATE OR COUNTRY)

10. NAME OF FATHER Robert Cox
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.
12. MAIDEN NAME OF MOTHER Helen Sacre
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.

14. INFORMANT Mrs. J.M. Cox
(Address) R.F.D. Fulton Mo.

15. May 26, 1929 R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/28 19 29
17. I HEREBY CERTIFY, That I attended deceased from 1929 to May 28, 19 29 that I last saw him alive on May 28, 19 29, and that death occurred, on the date stated above, at 5.30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dilatation of Heart
92 B
95 B
(duration) yrs. mos. ds.
CONTRIBUTORY Chronic Regurgitation
(SECONDARY) (duration) 7 yrs. 2 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?
(Signed) A. B. Ferguson, M. D.
, 19 (Address) Fulton 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 Hillcrest Cemetery DATE OF BURIAL 5/29 19 29

20. UNDERTAKER Herndon Taylor ADDRESS Fulton Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JUN 24 1929

