

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

Do not use this space.

15544

1. PLACE OF DEATH

County Carroll
Township Wagon Wheel
City Boyard (No.)

Registration District No. 133
Primary Registration District No. 4074

File No.
Registered No. 9
St. Ward)

2. FULL NAME

Delbert Lee Cox

(a) Residence. No. 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 nonresident, give city or town and State) 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)

sep 25-1919

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

8

6

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

Child

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Boyard Mo.
Carroll Co. Mo.

10. NAME OF FATHER

Delbert Cox

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

12. MAIDEN NAME OF MOTHER

Pracy

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Iowa

14.

INFORMANT
(Address)

Mrs. Delbert Cox
Boyard Mo.

15.

FILED 6/2 1930

Janie Henderson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

19

17.

I HEREBY CERTIFY, That I attended deceased from 5-30 to 5-31, 1930 that I last saw him alive on 5-31, 1930 and that death occurred, on the date stated above, at 11:30 PM.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia due to Bacillus Aerogenes Capsulatus or Gas Gangrene (duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY)

(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

(Signed)

H. B. Brown M. D.

6-1, 1930 (Address) Carroll Co. 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

DATE OF BURIAL

Boyard Mo.

June 2 1930

20. UNDERTAKER

ADDRESS

Ed Dukerson

Boyard Mo.

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 1930

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

3-30
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Carrroll Registration District No. 133 File No.
 Township Bogard Primary Registration District No. 4074 Registered No.
 City Delbert Lee Cox (No.) St. Ward)

2. FULL NAME Delbert Lee 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 M (write the word)

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)

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 6/2 39 Jania Henderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 1930

17. I HEREBY CERTIFY, That I attended deceased from
 19....., to 19.....
 that I last saw h. at 19....., and that
 death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

 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?

*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. - A 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 recorded. Exact statement of OCCUPATION is very important. SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

PH 551-5

