

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

Do not use this space.

MAR 4 1935

216,481

**1. PLACE OF DEATH**

County St. Louis  
Township McHenry  
City (No. ....) (No. ....) St. .... Ward)

Registration District No. 844

Primary Registration District No. 600

File No. ....

Registered No. ....

**2. FULL NAME**

Bert 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**

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)**

0

**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. X

(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) X

**10. NAME OF FATHER**

Alfred Cox

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) St. Louis Mo

**12. MAIDEN NAME OF MOTHER**

Josephine Taylor

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) St. Louis Mo

**14.**

INFORMANT Alfred Cox

(Address) Galena Mo R 2

**15.**

FILED

19 3

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

June 16 1930

**17.**

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to....., 19....., and that I last saw him alive on June 13 1930, and that death occurred, on the date stated above, at 10 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Myocardium

2003

(duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH Yes

**DID AN OPERATION PRECEDE DEATH? DATE OF**

WAS THERE AN AUTOPSY? no

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) J. J. ...

M. D.

, 19 30

(Address) Galena 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**

Josephine Center

June 16 1930

**20. UNDERTAKER**

**ADDRESS**

W. L. Craig

Galena Mo.

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

M. 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.



**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 Stone

Registration District No. 844

File No. 4071-

Township .....

Primary Registration District No. 6750

Registered No. 2

City (No. .... St. .... Ward)

**2. FULL NAME**

Beck Cox

(a) Residence, No. .... St. .... Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 2 (Write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 15, 1930  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19..

19. UNDERTAKER (ADDRESS)

20. FILED 7-15-35 Ola Magers Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 15, 1930

22. I HEREBY CERTIFY, That I attended deceased from ..... to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Unknown  
1003  
Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19.....  
Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....  
If so, specify.....

(Signed)....., M. D.  
(Address).....

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

SUPPLEMENTARY

8791E-5

6-1-9