NOV 21 1930

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

Do not use this space.

32134

1. PLACE OF DEATH

County: Buchanan — Registration District No. 85 — File No.

Township: — Primary Registration District No. 1001 — Registered No. 1110

City: St Joseph (No. State Hospital for Insane #2 St. ..... Ward)

2. FULL NAME John Cox

(a) Residence. No. State Hospital #2 St., ... Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Year 1890

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
about	40	Unk	Unk	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) England

PARENTS

10. NAME OF FATHER G. H. Cox
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) England
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) England

14. INFORMANT G. H. Cox
(Address) 3837 Broadway. K.C. Mo.

15. FILED OCT 8 1930 19 John G. Wh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 6th 1930

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1923, to Oct 6th, 1930 that I last saw him alive on Oct 6th, 1930, and that death occurred, on the date stated above, at 530 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myiocarditis.
436

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 906

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH No
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? Yes.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. R. Burch, M. D.
10/6/ 1930 (Address) State Hospital #2

*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
State Hospital for Insane #2 Cem	Oct. 8 1930
20. UNDERTAKER	ADDRESS
Herbon - Belgole & Bowman Funeral Home	319 S. 10

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.