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

Do not use this space.

22217

1. PLACE OF DEATH
County: Adair
Township: Clay
City: ..... (No. ....., ... St. ..... Ward)

Registration District No. 1023
Primary Registration District No. 5006

File No. .....
Registered No. 8

2. FULL NAME: Henry C. Fox

(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 (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 4" 1858

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
74	11	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(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): Adair, Co. Mo.

PARENTS

10. NAME OF FATHER: don't know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): don't know
12. MAIDEN NAME OF MOTHER: don't know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): don't know

14. INFORMANT: Carl Callahan
(Address) Kirksville Mo.

15. FILED Aug 8 1933 Martha M. Kennedy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 14 1933

17. I HEREBY CERTIFY, That I attended deceased from July 13, 1933, to July 14, 1933 that I last saw him alive on July 13, 1933 and that death occurred, on the date stated above, at 12:10 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
apoplexy
82A
(duration) ..... yrs. ..... mos. ..... ds.

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? general symptoms
(Signed) M. F. Kennedy, M. D.
7/15, 1933 (Address) Kirksville, 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: Willmarthsville
DATE OF BURIAL: 7/15" 1933

20. UNDERTAKER: F. R. Easley
ADDRESS: Bracken, 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.