

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

Do not use this space.

JUL 23 1935

19603

1. PLACE OF DEATH

County Jackson Registration District No. 398
 Township Independence Primary Registration District No. 3019
 City Independence (No. _____, _____ St. _____ Ward)

File No. _____
 Registered No. 202

2. FULL NAME

(a) Residence, No. 900 W. Delaware 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) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Finnia Cox
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 9 - 1868
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 2 21
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Junk dealer
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/22 1935
 22. I HEREBY CERTIFY That I attended deceased from Apr 15 1935 to June 22 1935
 I last saw him alive on June 6 1935 Death is said to have occurred on the date stated above, at 1 p m.
 The principal cause of death and related causes of importance were as follows:
Coronary Occlusion Date of onset 6/14/35
 Other contributory causes of importance _____
Coronary Occlusion

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis
 13. NAME Joe Cox
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT Milton Cox
 (ADDRESS) 900 W. Delaware
 18. BURIAL, CREMATION, OR REMOVAL PLACE Macedon Grave DATE June 25 1935
 19. UNDERTAKER (ADDRESS) W. Mitchell
 20. FILED 6-25-35 J. S. Cook Registrar

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no
 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? no
 If so, specify _____
 (Signed) Frank G. ..., M. D.
 (Address) Independence

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.

