

REC'D JUN 8 1939

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

17842

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 2
 (b) Township 1st Primary Registration District No. _____ Registered No. 2244
 (c) City R.C. Mo (d) Street No. 1524 Topping St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S. of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 5160 1902 1/2 Topping Ave St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF D. R. Minor
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 17 - 1892
 7. AGE YEARS 46 MONTHS 9 DAYS 12 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as 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) Mo
 FATHER 13. NAME James G. Cox
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland
 MOTHER 15. MAIDEN NAME Minor
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) William B. Minor 1524 Topping
 18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mary's DATE May 31
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robert Henderson R.C. Mo
 20. FILED May 31, 1939 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 29, 1939I HEREBY CERTIFY, That I attended deceased from 5/24/39, 19, to 5/29/39, 19.I last saw him alive on 5/29/39, 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:

Cancer of breast with metastasis (Date of onset 50)

Other contributory causes of importance: _____

Name of operation Amputation of breast 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? no

If so, specify _____

(Signed) L. R. Williams, M.D.(Address) St. Mary's Hospital

(Licensed Embalmer's Statement on Reverse Side)

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

I X14028

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.

1314
Burgess
1945

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.