

REC'D SEP 20 1939

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

29768
 Do not use this space.

1. PLACE OF DEATH

(a) County Morgan Registration District No. 598
 (b) Township Morgan Primary Registration District No. 7355
 (c) City VERSAILLES (d) Street No. _____ 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., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

200 Charles Anderson Cox
 (a) Residence, No. Morgan County, Mo. 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

MEDICAL CERTIFICATE OF DEATH

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 Missouri Smith
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 23-1858
 7. AGE YEARS 81 MONTHS 4 DAYS 0 If LESS than 1 day, _____ hrs. or _____ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 23, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 10, 1939 to August 23, 1939
 I last saw him alive on Aug 22, 1939 Death is said to have occurred on the date stated above, at 10 A. m.
 The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired farmer
 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 _____

Arteriosclerosis

Date of onset

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

Other contributory causes of importance:

Senility
Decompensation Cardiac 8-22-39

FATHER 13. NAME Thomas Cox
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia

Name of operation _____ Date of _____

What test confirmed diagnosis? Clinical Was there an autopsy? no

MOTHER 15. MAIDEN NAME Jones
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) West Virginia

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. _____

17. INFORMANT (ADDRESS) Mr. Sherman Cox
Versailles, Mo.

Manner of injury _____

Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Riser - Miller Co. DATE Aug 25-3924. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. F. Hedwell
Versailles, Mo.(Signed) J. L. Lawrence, M. D.20. FILED Sept 1, 1939 Wall & Berry
Versailles, Mo.
Local Registrar(Address) Versailles Mo

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,

Rene Bartram

, or by

Registered Apprentice No., working under my personal supervision

Signed

Rene Bartram

Licensed Embalmer No. *4021*

P. O. Address *Ursailles*

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

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