DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6749

FILED MAR 16 1940

Registration District No. 347 Primary Registration District No. V-5-485 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Henry

(b) City or town Urich, Rural Bogard
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days) 15 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Henry

(c) City or town Urich 0
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Lizzie Florance Cox

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Horace Cox, deceased

6. (c) Age of husband or wife if alive years

7. Birth date of deceased May (Month) 25 (Day) 1857 (Year)

8. AGE: Years 82 Months 8 Days 19 If less than one day hr. min.

9. Birthplace Boonville (City, town, or county) Mo (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name John Henderson

13. Birthplace Virginia (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name Lucinda Newberry

15. Birthplace Virginia (City, town, or county) (State or foreign country)

16. (a) Informant Earl Cox

(b) Address Urich Mo.

17. (a) Bel Cemetary (Burial, cremation, or removed) (b) Date thereof 2 (Month) 16 (Day) 1940 (Year)

(c) Place: burial or cremation Bilyeu Cemetary

18. (a) Signature of funeral director Hobart Arnold

(b) Address Creighton Mo.

19. (a) (Date received local registrar) (b) 2/16 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 14

year 1940 hour 11 minute 40 M.

21. I hereby certify that I attended the deceased from Feby 8 1940 to Feby 14 1940

that I last saw h alive on Feby 14 1940

and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pleuro Pneumonia	6 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN
Of autopsy	Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. G. McDonald (M. D. or other)

Address Urich Mo Date signed 2/15/40

3/20 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 3-MO-52
Date Filed 3-15-40

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 Ma

_____, Registered Apprentice No. 3621,

working under my personal supervision.

Signed Hobart Arnold

Licensed Embalmer No. 3621

P. O. Address Creighton, Mo.

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.

. S. No. 2B
M—2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6749

Registration District No. 347 Primary Registration District No. 5485 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Henry (b) City or town Boggard Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. 4
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Lizzie Florence Cox
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 82 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 4-6-40 (Date received local registrar) (b) Dr. J. R. Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pleura Pneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings:
Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature J. G. McDonald (M. D. or other)
Address Beach Mo. Date signed

SUPPLEMENTARY

S. No. 2B
M. 2-21-40
Y92659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6749

Registration District No. 347 Primary Registration District No. 3485 Registrar's No.

1. PLACE OF DEATH:

(a) County Henry (b) ~~City or town~~ Bogard rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME Lizzie Florence Cox

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 82 Months 8 Days 19 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pleural Pneumonia	
Due to Double Lobar	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature D. G. McDonald (M. D. or other)
Address Enid Okla. Date signed

SUPPLEMENTARY