

FILED AUG 3 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 25747

Registration District No. 566

Primary Registration District No. 3030

Registrar's No. 89

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

1. PLACE OF DEATH:  
 (a) County Mississippi  
 (b) City or town Charleston, Mo.  
 (c) Name of hospital or institution:  
Olive Street  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 15 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME Sam Cox  
 3. (b) If veteran, name war X X X 8. (c) Social Security No. X X X

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife Belle Cox 6. (c) Age of husband or wife if alive 15 years  
 7. Birth date of deceased April 18 1886  
 (Month) (Day) (Year)

8. AGE: Years 54 Months 2 Days 18 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business Farming

MOTHER FATHER  
 { 12. Name Not known  
 { 13. Birthplace Not known not known  
 { 14. Maiden name Not known  
 { 15. Birthplace Not known not known  
 (City, town, or county) (State or foreign country)

16. (a) Informant Earnest Cox  
 (b) Address 303 S. Heggie St. Charleston

17. (a) Burial (b) Date thereof 7-5-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Charleston, Mo.

18. (a) Signature of funeral director Lair-Nunnelee Service  
 (b) Address Charleston, Mo.

19. (a) 7-9-40 (b) J. D. Brown  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Mississippi  
 (c) City or town Charleston, Mo.  
 (d) Street No. Olive Street  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 3  
 year 1940 hour 11 minute 45 M.

21. I hereby certify that I attended the deceased from about June 18 1940 to July 3 1940  
 that I last saw him alive on June 31 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia

Due to Myocarditis

Due to \_\_\_\_\_

Other conditions Senility  
 (Include pregnancy within 3 months of death)  
Fract of left foreleg

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? 375

(Specify type of place) While at work \_\_\_\_\_  
 (Specify means of injury)

23. Signature E. Chao M. D. or other \_\_\_\_\_  
 Address Charleston Mo Date signed 7/5/40

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

174 B  
99

RECEIVED

District Health Officer No. 2

Case File Number 840-1281

Date Filed 8/2/40

**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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed John F. Nunnelee Jr

Licensed Embalmer No. 3851

P. O. Address Charleston 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 25747

Registration District No. 566

Primary Registration District No. 3030

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Charles Mississippi

(b) City or town Charleston Mo  
(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. \_\_\_\_\_  
(If rural, give location)

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

3. (a) PRINT FULL NAME Sam Cox

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month July day 3  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m 5. Color col 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)

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

8. AGE: Years 54 Months 2 Days 18 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min.

Immediate cause of death Hypostatic pneumonia Duration \_\_\_\_\_

Due to myocarditis 2/12/40

Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) Senility

10. Usual occupation \_\_\_\_\_

Major findings: fracture of left foreleg! PHYSICIAN \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

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) accident

(b) Date of occurrence 6/18/40

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
on street - hit by car

While at work? no (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature E. Cox Palmering (M. D. or other) \_\_\_\_\_

Address Charleston Mo Date signed 9/11/40

SUPPLEMENTARY

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

