6 23 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26154

Registration District No. 775 Primary Registration District No. 6030-A Registrar's No. 52

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

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bonne Terre Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1/2 hour (Specify whether
In this community ✓ years, months or days)

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

3. (a) PRINT FULL NAME KATHERINE MATILDA 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 Married
6. (b) Name of husband or wife Jess E. Cox
6. (c) Age of husband or wife if alive 41 years
7. Birth date of deceased Aug (Month) 7 (Day) 1896 (Year)

8. AGE: Years 43 Months 11 Days 8 If less than one day ____ hr. ____ min.

9. Birthplace Fredericktown (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Housewife
11. Industry or business Own home
FATHER
12. Name Peter F. Frye
13. Birthplace Louisville (City, town, or county) Kentucky (State or foreign country)
MOTHER
14. Maiden name Florence Mathews
15. Birthplace (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. Sid Boyer
(b) Address 111 E Second St. DeSoto, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Fredricktown Mo
18. (a) Signature of funeral director Ed H. Webb
(b) Address Fredricktown
19. (a) July 16, 1940 (Date received local registrar) (b) N. W. Hawkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15th year 1940 hour 6 minute A. M.
21. I hereby certify that I attended the deceased from By Inquest duties July 15, 1940
that I last saw h____ alive on ____, 19__;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Jury Verdict Deceased came to her death as a result of injuries	
Due to sustained in an unavoidable accident ✓	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy None	

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) Accidental
(b) Date of occurrence July 15, 1940
(c) Where did injury occur? 4 miles N of Bonne Terre Highway 61 (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 6 Public Place Highway 61 (Specify type of place)
While at work? No (e) Means of injury Fractured Skull
23. Signature Jos D Cemer (M. D. or other) Coroner 5
Address Flat River Mo Date signed 7-15-40

(Licensed Embalmer's Statement on Reverse Side)

210m
98

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 Myron A. La Pee, Registered Apprentice No. ____, working under my personal supervision.

Signed Myron A. La Pee

Licensed Embalmer No. 4025

P. O. Address Frederick Town, Md.

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.

. No. 2B
—2-21-40
I X22659

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

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26154
Registrar's No. 52

Registration District No. 775 Primary Registration District No. 6020A

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre
(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 Katherine Matilda 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 m
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 43 Months 11 Days 8 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)
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)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 15
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.

Immediate cause of death — Duration
Jury Verdict Deceased came to her death as a result of injuries sustained in an
Due to automobile accident
Head on collision with
Other conditions automobile
(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?
While at work? (Specify type of place) (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY