

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
AUG 19 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

28421

Registration District No. 281

Primary Registration District No. 3420

State File No.

Registrar's No. 40

1. PLACE OF DEATH:

(a) County: Douglas  
(b) City or town: Ave., Rural Washington  
(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: 2 (Specify whether  
In this community: years, months or days)

8. (a) PRINT FULL NAME: Opal Cox 207

8. (b) If veteran, name war: 8. (c) Social Security No. None

4. Sex: Female 5. Color or race: White 6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Unie Cox 6. (c) Age of husband or wife if alive: 1 years

7. Birth date of deceased: June 20 1909 (Month) (Day) (Year)

8. AGE: Years 31 Months 1 Days 17 If less than one day hr. min.

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

10. Usual occupation: Housewife

11. Industry or business:

12. Name: Larder Wilson

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

14. Maiden name: Mirtie Fletcher

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

16. (a) Informant: Unie Cox

(b) Address: Ave. No. Route 3.

17. (a) Burial (b) Date thereof: 8-8-40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Spring Creek

18. (a) Signature of funeral director: Friends

(b) Address:

19. (a) (Date received local registrar) (b) Reba King, White (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Douglas  
(c) City or town: Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Route 3.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7th year 1940 hour 6:00 minute M.

21. I hereby certify that I attended the deceased from July 15, 1940 to August 6th, 1940 that I last saw her alive on August 6th, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Heart Lesage Duration

Due to:

Due to:

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

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?

976 (Specify type of place) While at work? (e) Means of injury

23. Signature: Dr. J. C. Ellis (M. D. or other)

Address: Boone, Mo. Date signed:

RECEIVED

District Health Officer No. 6,

District File Number 940-2524

Date Filed SEP 04 1940

JUN 13 1950

**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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **28421**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **281**

Primary Registration District No. **5400**

Registrar's No. **40**

1. PLACE OF DEATH:

(a) County **Douglas**  
(b) City or town **Washington**  
(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

**Opal Cox**

3. (b) If veteran,  
name war

3. (c) Social Security  
No.

4. Sex **F**

5. Color **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

Months

Days

If less than one day

**31**

**1**

**17**

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

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) (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) **8-22-1940**

(Date received local registrar)

(b) **Reba King White**

(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

DEATH CERTIFICATION

20. DATE OF DEATH Month **Aug** day **7**

year **1940** hour minute M.

21. I hereby certify that I attended the deceased from

19 to 19

that I last saw him alive on  
and that death occurred on the date and hour stated above.

Immediate cause of death

Duration

Due to

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 sta-  
tistically.

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

