

FEB 18 1941

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N. 11-10-39 5-17-39 I X21492

DEPARTMENT OF COMMERCE BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 3

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

1. PLACE OF DEATH:

(a) County Vermon

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

(c) Name of hospital or institution:
State Hosp #3 Nevada Mo
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8yr 4 da
(Specify whether)

In this community Life
years, months or days)

3. (a) PRINT FULL NAME Robert F. Cox

8. (b) If veteran, name war unknown

8. (c) Social Security No. none

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased 1 17 1882
(Month) (Day) (Year)

8. AGE: Years 58 59 Months 11 Days 15 If less than one day hr. _____ min.

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

10. Usual occupation Harmon

11. Industry or business _____

MOTHER FATHER { 12. Name Melvin Cox

13. Birthplace Crab Orchard 1 Ky.
(City, town, or county) (State or foreign country)

14. Maiden name Johanne McNeill

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

16. (a) Informant State Hosp #3 Nevada Mo

(b) Address _____

17. (a) Burial (b) Date thereof Jan 4 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lamar Mo

18. (a) Signature of funeral director Allen V. Hays

(b) Address Lamar Mo

19. (a) 1-3-41 (b) Allen V. Hays
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Barton 108

(c) City or town Lamar
(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 1 day 2
year 1941 hour 4 minute 50 P. M.

21. I hereby certify that I attended the deceased from 1-25-41
25, 1939 to 1-2, 1941;
that I last saw h. 1-2 alive on 1-2, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to General Arteriosclerosis

Due to _____

Other conditions Chronic Myocarditis
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy gaf

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?
795
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature State Hosp #3 (M. D. or other) OTM
Address _____ Date signed 1/7/1941

RECEIVED

District Health Officer No. 7,

District File Number 2-41-205

Date Filed 2-5-41

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 Albert J. Mann

Licensed Embalmer No. 3876

P. O. Address Jamaica N.Y.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 4705-
Registrar's No. _____

Registration District No. 876-

Primary Registration District No. 6162

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

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Washington T.P.
(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 _____
In this community _____ (Specify whether 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 Robert F Coy

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

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

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

7. Birth date of deceased 1-17-1882
(Month) (Day) (Year)

8. AGE: Years 58 Months 11 Days 15
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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-2-41 (b) Allen V. Hays
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH Month Jan day 2
year 1941 hour _____ minute _____ M.

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.
Immediate cause of death _____

Due to _____
Due to _____

Other conditions _____
(Exclude pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration _____
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 F. C. Long (M. D. or other) _____

Address Nevada St Date signed _____

SUPPLEMENTARY

