

No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

21545

State File No.

Registration District No. 242

Primary Registration District No. 5-335

Registrar's No.

1. PLACE OF DEATH:

(a) County Dallas

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

(c) Name of hospital or institution:
Buffalo Mo. 1
(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 Mo (b) County Dallas

(c) City or town RURAL 30
(If outside city or town limits, write "RURAL")

(d) Street No. Buffalo Mo. 1
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME James Aedfern Cox

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Name of husband or wife Ada Cox 6. (a) Single, widowed, married, divorced M

7. Birth date of deceased Aug. 20 1864
(Month) (Day) (Year)

6. (c) Age of husband or wife if alive 68 years

8. AGE:

Years	Months	Days	If less than one day
<u>76</u>	<u>9</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER { 12. Name James R. E. Cox

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

14. Maiden name Amanda Jones

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

16. (a) Informant Mrs J. R. Cox

(b) Address Buffalo Mo.

17. (a) Byrial (b) Date thereof 6-13-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Hope Cem.

18. (a) Signature of funeral director L. B. James

(b) Address Buffalo Mo.

19. (a) 7-4-41 (b) Mrs. J. R. Cox
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 11
year 1941 hour 2 minute 7 M.

21. I hereby certify that I attended the deceased from Oct 1939 to 6-11-41, that I last saw him alive on June 9 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of prostate gland

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? 219

While at work _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. H. Hemmer (M. D. or other) M.D.

Address Buffalo Mo Date signed 6-30-41

Duration

2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

C
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O

171342

RECEIVED

District Health Office No. 7,

Series File Number 7-41-1168

Date Filed 7-7-41

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 Clyde Montgomery

Licensed Embalmer No. 3592

P. O. Address Buffalo, 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, fact should be so stated above.