

FILLED OCT 24 1941
Registration District No. **034**

Primary Registration District No. **3008**

1. PLACE OF DEATH:
(a) County **Callaway**
(b) City or town **Fulton**
(c) Name of hospital or institution: **State Hospital No. 12**
(d) Length of stay: In hospital or institution **2 mo 4 days**
In this community **2 mo 4 days**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Andrew**
(c) City or town **Mexico**
(d) Street No. **1**
(e) If foreign born, how long in U. S. A. **0** years.

3. (a) PRINT FULL NAME **EDGAR - FOX**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **68** Months Days If less than one day
Ap. hr. min.

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

10. Usual occupation **Handyman**

11. Industry or business _____

MOTHER FATHER { 12. Name **deceased**

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant **Records** (b) Address _____

17. (a) ~~Grand Burial~~ (b) Date thereof **9-17-41** (Month) (Day) (Year)

(c) Place: burial or cremation **Mexico Mo**
18. (a) Signature of funeral director **East E. Orndt**
(b) Address **Mexico Mo**
19. (a) **9-16-41** (b) **R. N. Creva** (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month **Sept** day **15** year **1941** hour **6** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **July 1**, 19 **41**, to **Sept 15**, 19 **41**.
that I last saw him alive on **Sept 15**, 19 **41**, and that death occurred on the date and hour stated above.

Immediate cause of death: **terminal broncho-pneumonia** Duration _____

Due to **chronic myocarditis**

Due to **mediastinal tumor**

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 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? _____

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

23. Signature **Joseph Imperatore** (M. D. or other) **M.D.**
Address **Fulton Mo** Date signed **Sept 15**

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..... *Earl E. Pugh*.....

Licensed Embalmer No. *3189*.....

P. O. Address *Merida, Mo.*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31214

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton
(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 Missouri (b) County Andrew
(c) City or town Mexia
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Edgar Fox

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 w

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 68 Months _____ Days _____ (If less than one day _____ min.)

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

10. Usual occupation

11. Industry of 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) Sept 16, 1941 (b) R. N. Creeve (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day _____ year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to terminal broncho-pneumonia

Due to chronic myocarditis

Due to medicinal tumor carcinoma

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy HFB

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 _____

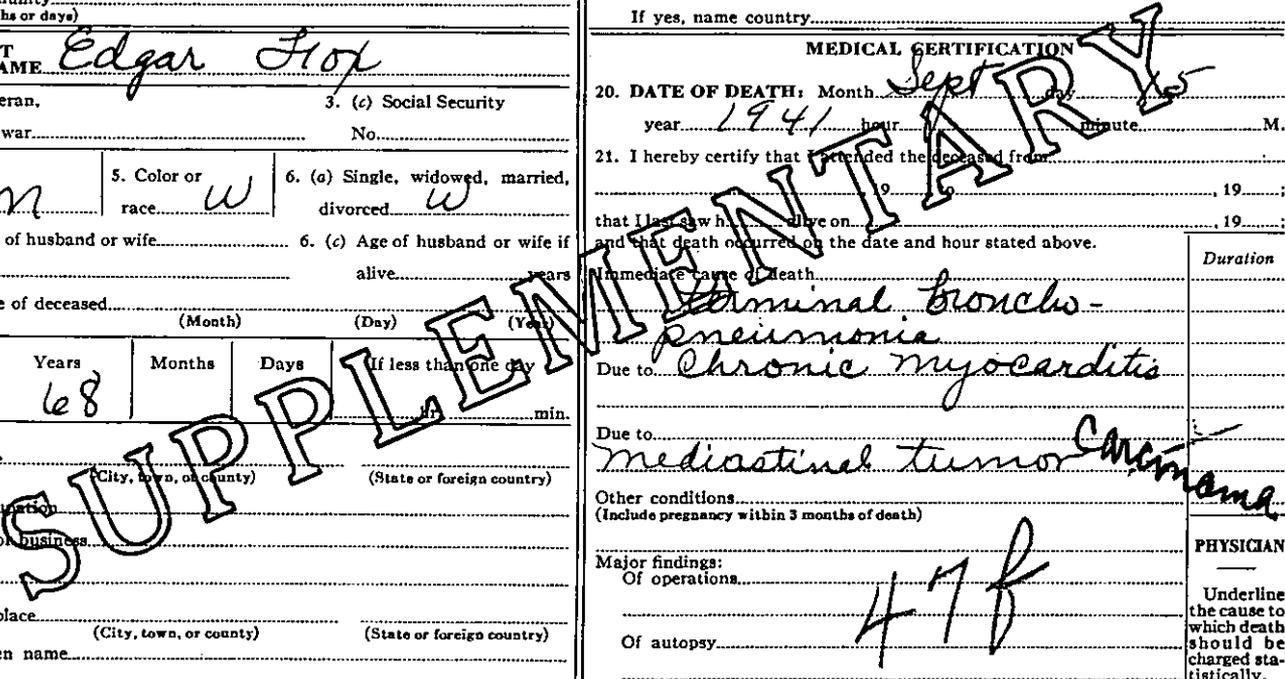
23. Signature Joseph S. ... (M. D. or other)

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.



MOTHER FATHER

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

Nov. 3, 1941.

S-31215 1941