

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 4489

FILED DEC 18 1942  
Registration District No. 179

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 2226 Brighton /  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 4 Days  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Benton  
 (c) City or town Warsaw (If outside city or town limits, write "RURAL")  
 (d) Street No. Rural Route # 3 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Thomas Cleveland Box  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 3rd  
 year 1942 hour 5 minute 00 P.M.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Mrs. Pearl Box  
 6. (c) Age of husband or wife if alive 49 years  
 7. Birth date of deceased January 30 1886  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Pathologist to \_\_\_\_\_ 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

8. AGE: Years 56 Months 10 Days 3 If less than one day  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death \_\_\_\_\_  
Hemorrhage

9. Birthplace Windsor Missouri  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Farmer

Due to Rupture of Descending Aorta  
 Due to Aorta  
 Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
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MOTHER FATHER {  
 11. Industry or business \_\_\_\_\_  
 12. Name James N. Box  
 13. Birthplace Ind. (State or foreign country)  
 14. Maiden name Sarah Flynn  
 15. Birthplace Ill. (State or foreign country)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy as above  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Pearl Box  
 (b) Address Warsaw, Missouri R. R. 3  
 17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-4-42  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation Warsaw, Missouri  
 18. (a) Signature of funeral director J. Wagner  
 (b) Address Rt. 1, Mo.  
 19. (a) 12-4-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

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 Frederick C. ... (M. D. or other) \_\_\_\_\_  
 Address Research Hospital Date signed 12/4/42

**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..... *Cecil R. Matthes* .....

Licensed Embalmer No. *3807* .....

P. O. Address *Kansas City, Mo.* .....

**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.**