

FILED JAN 11 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4908

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: St. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 yrs.
In this community 22 yrs.
years, months or days (Specify whether)

3. (a) PRINT FULL NAME WILLIAM COX

3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Male 5. Color or race wh
6. (a) Single, widowed, married, divorced single
6. (c) Age of husband or wife if alive 7 years
7. Birth date of deceased 11-7-1885
(Month) (Day) (Year)

8. AGE: Years 57 Months 10 Days 22
If less than one day by min.

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

10. Usual occupation Mecha Film Co

11. Industry or business

12. Name Wm. F. Cox

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

14. Maiden name Rose Jennings

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

16. (a) Informant Mrs. Lillian Klein

(b) Address 2821 Holmes

17. (a) Burial (b) Date thereof 12-31-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director J. H. Daniels

(b) Address 7th + Kansas St. N. C. 70

19. (a) 12-30-42 (b) Margaret D. Crane
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2821 Holmes Street
(If rural, give location)
(e) Citizen of foreign country? No
If yes, name country A

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29th
year 1942 hour 3 minute 42 P. M.

21. I hereby certify that I attended the deceased from 7-2-42
19 12-29-42 to 12-29-42, 19 im
that I last saw h im alive on 12-29-42, 19 im
and that death occurred on the date and hour stated above.

Immediate cause of death
CARCINOMA OF THE LARYNX

Due to 77W
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy none

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 Dr. P. J. ... (M. D. or other)
Address Med. Bldg. K. C. Gen. Hospital
Date signed

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

MOTHER, FATHER

Port. 1953

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..... *Ralph H. Runnels*

Licensed Embalmer No..... *3860*

P. O. Address *1318 E. 29th St., Kansas City*

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.