

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1565

State File No.

Registrar's No. 136

Registration District No. 1942

Primary Registration District No. 1000

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

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
223 N. 8th St.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____ 20 years _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. 223 N. 8th St.
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT Michael J. Cox
 FULL NAME
 3. (b) If veteran, name war no
 3. (c) Social Security No. none

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Mary Cox
 6. (c) Age of husband or wife if alive 70 years
 7. Birth date of deceased Sept. 28 1970
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>3</u>	<u>29</u>	hr. _____ min.

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

10. Usual occupation Retired Grading Contractor

11. Industry or business _____

MOTHER, FATHER {
 12. Name Michael J. Cox
 13. Birthplace Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Ellen
 15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Cox

(b) Address 223 N 8th St. St Joseph, Mo.

17. (a) Burial (b) Date thereof Jan. 29, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Robert Masterson
 (b) Address 5025 King Hill Ave.

19. (a) 1-29-43 (b) Rose Heroy
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 27
 year 1943 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from Jan 22 1943 to Jan 26 1943
 the I last saw him alive on Jan 26 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris

Due to arteriosclerotic

Due to _____

Other conditions hypertension
(Include pregnancy within months of death)

Major findings:
 Of operations _____
 Of autopsy no

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 Rose Heroy (M. D. or other) _____

Address 670 Francis Date signed 1/27/43

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.....



Licensed Embalmer No. **4238**

P. O. Address..... **St. Joseph**

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.