

7. S. No. 2
FORM 1-5-42
Rev. 5-17-39
21 X32873

10917

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 9 1943

Registration District No. 1928

Primary Registration District No. 4338

Registrar's No. 17

69
0

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

1. PLACE OF DEATH:

(a) County MONROE

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

(c) Name of hospital or institution:
Mount WINTER ST
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution, write street number or location
(Specify whether)

In this community 15 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County MONROE

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

(d) Street No. WEST WINTER ST
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Paul. Cox.

3. (b) If veteran, name war.....

3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20
year 1943 hour..... minute..... M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Lulah M.

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

7. Birth date of deceased March 12 1879
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
MARCH 16 1943 to MARCH 20 1943
that I last saw him alive on MARCH 16 1943
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

64 0 18 hr. min.

Immediate cause of death.....
CEREBRAL APOPLEXY

Due to CEREBRAL THROMBOSIS

Due to.....

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Farm Laborer

11. Industry or business.....

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Martin Cox

13. Birthplace 1012 Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth DEN

15. Birthplace Ken D.C. Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant John Nelson

(b) Address Monroe City Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-43
(Month) (Day) (Year)

(c) Place: burial or cremation ST JUDES, MONROE CITY

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 Harold F. Ellis (M. D. or other) D.O.
Address Monroe City Date signed 3-20-43

18. (a) Signature of funeral director WILSON & SONS

(b) Address MONROE CITY MO

19. (a) Mar. 21 1943 (b) Otis Hedberg
(Date received local registrar) (Registrar's signature)

1126

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 4-43-677

Date Filed APR 8 1943

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 By me

Registered Apprentice No. _____

working under my personal supervision.

Signed Leslie R. Wilson

Licensed Embalmer No. 3014

P. O. Address Monroeville, 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: