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State File No. 21324
Registrar's No. 41924

Registration District No. 128
378

Primary Registration District No. 5466

1. PLACE OF DEATH:

(a) County GARDNER

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

(c) Name of hospital or institution: MEDICAL CENTER FOR FEDERAL PRISONERS
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Mos., 21 days.
(Specify whether years, months or days)

In this community 2 Months, 21 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) ~~AKA~~ Alaska (b) County 39

(c) City or town Yakutat
(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 COX, Jim

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race Indian 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased May 15 1915
(Month) (Day) (Year)

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

✓ 28 1 1 hr. _____ min.

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

10. Usual occupation laborer

11. Industry or business canneries

MOTHER FATHER

12. Name Tom Cox

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

14. Maiden name Sally (unknown)

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

16. (a) Informant File

(b) Address MCFP

17. (a) burial (Burial, cremation, or removal) (b) Date thereof June 30/1943
(Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cemetery.

18. (a) Signature of funeral director Fred G. Thieme

(b) Address Springfield, Mo.

19. (a) 6-28-43 (Date received local registrar)

(b) R. W. McComas (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1943 hour 3 minute 52 AM.

21. I hereby certify that I attended the deceased from March 26, 1943 to June 16, 1943
that I last saw him alive on June 16, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death tuberculosis, pulmonary, chronic, far advanced, bilateral.

Due to _____

Due to _____

Other conditions entero-colitis, tuberculosis, pneumothorax, artificial, left

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy NO

Duration _____

prior to admission

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 R. W. McComas (D. M. D. 1930)

Address MCFP Date signed 6-18-43

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

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 **Fred O. Thieme**

Licensed Embalmer No. **2899**

P. O. Address **Springfield, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 494

1. PLACE OF DEATH:

(a) County Greene
(b) City or town S. Campbell Ave
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Medical Center Federal Prison
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo
In this community 2 mo (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Jim Cox

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race Indian
6. (a) Single, widowed, married, divorced S.

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

7. Birth date of deceased May 15
(Month) (Day) (Year)

8. AGE: Years 28 Months 1 Days _____ If less than one day, _____ min.

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

10. Usual occupation

11. Industry or 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Dr. W. H. Stanley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1943 hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

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? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

521324