

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28013**
Registrar's No. **56**

FILED SEP 9 1943
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Registration District No. **75**

Primary Registration District No. **3015**

1. PLACE OF DEATH:
(a) County **Clinton**
(b) City or town **Cameron**
(c) Name of hospital or institution: **West Prairie St.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **NO.**
In this community **2 1/2 yrs.**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Clinton**
(c) City or town **Cameron**
(If outside city or town limits, write "RURAL")
(d) Street No. **West Prairie St.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Sarah M Cox.**
3. (b) If veteran, name war **No.**
3. (c) Social Security No. **No.**

4. Sex **Female** 5. Color or race **W**
6. (a) Single, widowed, married, divorced, **widowed**
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive **17** years **1853**
7. Birth date of deceased **Mch. 17 1853**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
90 4 25 hr. min.

9. Birthplace **Morgan Co. ILL. /**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business
12. Name **No Record**
13. Birthplace **No Record**
(City, town, or county) (State or foreign country)
14. Maiden name **No Record**
15. Birthplace **No Record**
(City, town, or county) (State or foreign country)

16. (a) Informant **W.A. Cox**
(b) Address **Cameron Mo.**

17. (a) **Burial** (b) Date thereof **8-15-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Evergreen cemetery**

18. (a) Signature of funeral director **Poland Funeral Home**
(b) Address **Cameron Mo.**

19. (a) **8-14-43** (b) **Mrs. Kathleen Harris**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **12**
year **1943** hour **11:05 P.M.** minute **M.**

21. I hereby certify that I attended the deceased from **July 15** to **Aug 12**, 19**43**
that I last saw him **alive on Aug 9** and that death occurred on the date and hour stated above.

Immediate cause of death **Parapneuma of the face**
Duration

Due to **53**

Due to **53**

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 industry, place, in public place?

While at work (Specify type of place) (e) Manner of injury
23. Signature **[Signature]** M. D. (Other)
Address **Cameron Mo.** Date signed **Aug 13/43**

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 Aerald T. Wade.....

Licensed Embalmer No. 4172.....

P. O. Address Cameron 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.