

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

FILED DEC 17 1943

42493  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 150  
 (b) Township Prairie Primary Registration District No. 42-94 Registered No. 140 48  
 (c) City Greenwood, Mo. (d) Street No. 1 St. 0  
 (e) Length of residence in city or town where death occurred 35 (If death occurred in Hospital or Institution, write its name instead of street and number) yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Calvin Cox  
 (a) Residence, No. Greenwood Mo. St.  (If nonresident, give city or town and State) 0  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Arnie E. Cox

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) December 18 1858

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>84</u>	<u>10</u>	<u>20</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 2 yrs. ago

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jacksonville Illinois

FATHER

13. NAME Joseph Cox

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER

15. MAIDEN NAME Sarah Spainhour

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT Walter E. Cox  
(ADDRESS) Lee's Summit, Mo.

18. BURIAL, CREMATION, OR REMOVAL Burial  
PLACE Greenwood, Mo. DATE Nov. 9 1943

19. FUNERAL DIRECTOR (NAME) N. B. Langford  
(ADDRESS) Lee's Summit, Mo.

20. FILED Nov. 8 1943 F. Th. Schieb Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 6 1943

22. I HEREBY CERTIFY, That I attended deceased from Nov. 1 1943 to Nov 6 1943  
 I last saw him alive on Nov 3 1943 Death is said to have occurred on the date stated above, at D. U. S. M.  
 The principal cause of death and related causes of importance were as follows:

Date of onset Oct 27, 43

Emphysema

83a1

Other contributory causes of importance:  
Arteriosclerosis  
Cerebral Hemorrhage

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) J. L. Henschel, M. D.  
 (Address) Pleasant Hill, Mo.

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**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. *3233*

P. O. Address *Leis Summit*

**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, above space should be left blank.**