

**FILED MAY 15 1944**

Registration District No. \_\_\_\_\_

Primary Registration District No. **3002**

Registrar's No. **50**

1. PLACE OF DEATH:

(a) County **Audra in**  
(b) City or town **Mexico**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Audrain Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 da**  
(Specify whether years, months or days)  
In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Audrain**  
(c) City or town **Mexico**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **R. #. 1 Fairview Add.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

**Baby Fox**

3. (b) If veteran, name war **No**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S O**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **April 8, 1944**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**-- --- -- 10** hr. min.

9. Birthplace **Mexico, Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Baby**

11. Industry or business \_\_\_\_\_

12. Name **Hadley Fox**  
13. Birthplace **Mexico, Mo.** (City, town, or county) (State or foreign country)  
14. Maiden name **Mary B. Newsome**  
15. Birthplace **Mexico, Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Hadley Fox**  
(b) Address **Mexico, Mo.**

17. (a) **Burial** (b) Date thereof **4/10/44**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ELMWOOD**  
18. (a) Signature of funeral director **Crosby**  
(b) Address **Mexico, Mo.**

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **9**  
year **1944** hour **5:45** minute **41** M.

21. I hereby certify that I attended the deceased from **April 8 (6:44 PM) 1944** to **April 9 1944**  
that I last saw **her** alive on **April 8** and that death occurred on the date and hour stated above.

Immediate cause of death **Premature Birth (twins)**

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions **Multiple pregnancy stillborn twins**  
(Include pregnancy within 6 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy **159**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **no**  
(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 **W. Brashear** (M. D. or other) **MD**  
Address **Mexico, Mo.** Date signed **4/10/44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10.

District File Number 5-44-995

Date Filed MAY 12 1944

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 *[Signature]*, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed *[Signature]*

Licensed Embalmer No. 3569

P. O. Address *[Signature]*

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.

Registration District No. 10 Primary Registration District No. 3002

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

1. PLACE OF DEATH:

(a) County Andrew

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

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Baby Fox

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race w 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 April 8  
(Month) (Day) (Year)

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

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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 4/10/44

19. (a) \_\_\_\_\_ (b) Margaret H Mackie  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Year 1944 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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 \_\_\_\_\_

13990