

S. No. 2
DM-5-42
v. 5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28208

FILED SEP 13 1944

Registration District No. 187

Primary Registration District No. 4302

Registrar's No. 99

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

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Chula
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME SARAH ANN COX

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife J. Monroe Cox 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased March 11 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Brandy Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Jim Nichols
13. Birthplace Don't know 9
(City, town, or county) (State or foreign country)
14. Maiden name Don't know
15. Birthplace Don't know 9
(City, town, or county) (State or foreign country)

16. (a) Informant J. Monroe Cox
(b) Address Chula, Mo.
17. (a) Burial (b) Date thereof Aug 17 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Plain view

18. (a) Signature of funeral director J. Robertson
(b) Address Tarado Mo.

19. (a) Aug 22 (b) Lois Ella Curry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston
(c) City or town Chula 59
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15
year 1944 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from Aug 5th
1944 to Aug 15th 1944
that I last saw him alive on Aug 15th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death:
Chronic Myocarditis and
Myocardial Degeneration,
Due to specified cor pulmonale
Posterior heart block

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

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)
(c) Means of injury _____

23. Signature B. Lee Shelton (M.D. or other) MD
Address Box 197, Tarado Mo. Date signed 8-16-44

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 *E. J. Robertson*
Licensed Embalmer No. *2468*
P. O. Address *Jaredo, 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.