

FILED FEB 8 1945

State File No.

Registration District No. 321

Primary Registration District No. 322

Registrar's No. 7

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fitzgibbons Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 weeks
In this community All her life
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Saline
(c) City or town Sweet Springs, Mo. Route # 1
(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 Minnie Mayse Cox
(b) If veteran, name war _____ (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan, day 12th
year 1945 hour 8 minute 45 A.M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William Arthur Cox 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 3rd, 1885
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 12 1945 to Jan 12 1945
that I last saw him alive on Jan 12 1945
and that death occurred on the date and hour stated above.
Immediate cause of death _____

8. AGE: Years Months Days If less than one day
59 9 9 _____ hr. _____ min.

Duration
Carcinoma of uterus -
Due to _____
Due to _____

9. Birthplace Saline county Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Housekeeper
11. Industry or business _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings of operations Biopsy - 4/13
Of autopsy _____

MOTHER FATHER {
12. Name James Madison Mayse
13. Birthplace Saline county Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Mary Keeth
15. Birthplace Saline county Missouri
(City, town, or county) (State or foreign country)
16. (a) Informant Mrs. M. Cox
(b) Address Sweet Springs, Mo. Route # 1
17. (a) Burial (b) Date thereof Jan. 14, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Hazel Grove cemetery
18. (a) Signature of funeral director Chas. S. Lewis
(b) Address Marshall, Mo.
19. (a) 1-16-45 (b) _____ (Registrar's signature)
(Date received local registrar)

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? _____
(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature J. R. Lawrence (M. D. or other) _____
Address Marshall Date signed Jan 13-45

1211

RECEIVED

District Health Officer No. 8,

Medical File Number -----

Date Filed 2-9-45

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

R. W. Campbell Jr.

Licensed Embalmer No. 3469

P. O. Address Marshall M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 327

Primary Registration District No. 3072

1. PLACE OF DEATH:

(a) County Saline
(b) City or town marshell
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Minnie M. Cox

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 M

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

7. Birth date of deceased: April 3 (Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days _____ (Unless 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 _____

19. (a) 1-16-45 (b) M. T. Weeber (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 Jan an _____
year 1945 - 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 _____

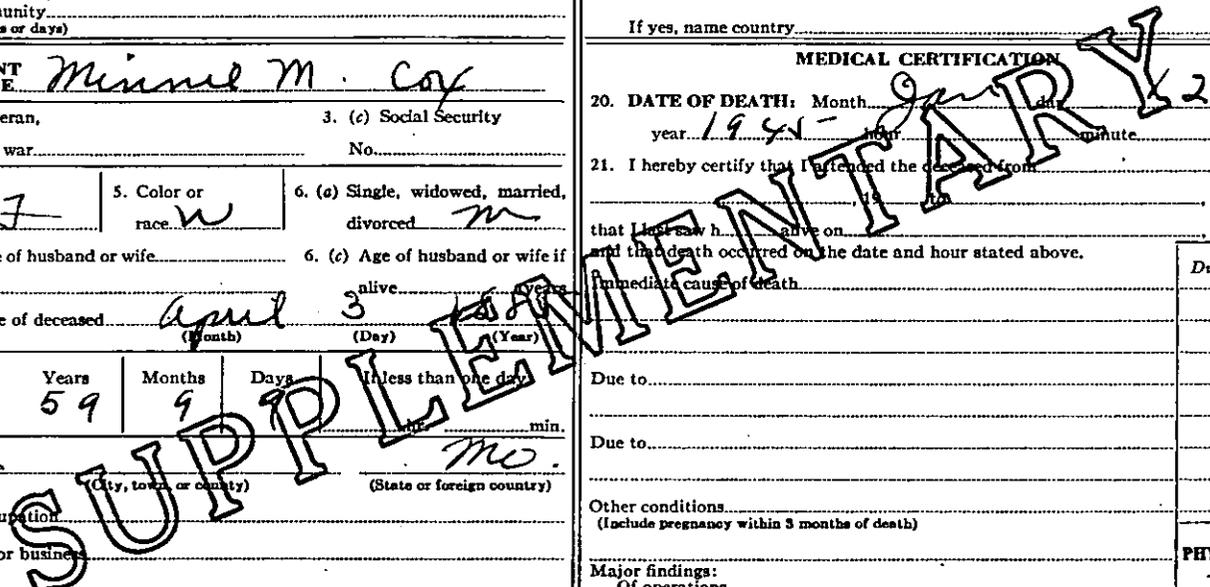
(c) Where did injury occur? _____ (City or town) (County) (State)

(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

3701