S. No. 2
M—5-42
v. 5-17-39
I X32873

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

Dr. G. W. Whitaker

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10209

FILED MAR 26 1945

Registration District No. 2 Primary Registration District No. 5789 Registrar's No. 11

1. PLACE OF DEATH:
(a) County: Mississippi
(b) City or town: Wolf Island, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Residence (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution, (Specify whether) In this community 22 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Mississippi
(c) City or town: Rural (If outside city or town limits, write "RURAL")
(d) Street No.: 2 Miles South E. of E. Prairie (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: JOHN HENRY COZART
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: 315-24-7590
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Bertha Belle Cozart
6. (c) Age of husband or wife if alive: 63 years
7. Birth date of deceased: Dec. 28, 1878 (Month) (Day) (Year)

8. AGE: Years 66 Months 1 Days 9 If less than one day hr. min.

9. Birthplace: Calhoun Co. (City, town, or county) Miss. (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: —
12. Name (FATHER): Hiram Thomas Cozart
13. Birthplace (FATHER): Calhoun (City, town, or county) Miss. (State or foreign country)
14. Maiden name (MOTHER): Polly Ann Perry
15. Birthplace (MOTHER): Calhoun Co. (City, town, or county) Miss. (State or foreign country)
16. (a) Informant: Effie M. Sigler
(b) Address: Mummerville, Tenn. Rt. 2
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-8-45 (Month) (Day) (Year)
(c) Place: burial or cremation: W. O. W.
18. (a) Signature of funeral director: Travis Shelby
(b) Address: East Prairie Mo.
19. (a) 3-10-1945 (Date received local registrar) (b) Fannie C. Bryman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 7 year 1945 hour 4:40 minute a. m.
21. I hereby certify that I attended the deceased from Jan 1, 1945, to Feb 7 - 1945, that I last saw him alive on Feb 6 - '45, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral apoplexy — Duration
Due to: Arteriosclerosis
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: JZN
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? (Specify type of place)
While at work? (e) Means of injury:
23. Signature: Geo W Whitaker (M. D. or other)
Address: East Prairie Mo. Date signed 3/2/45

1271

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 345-443
Date Filed 3/14/43

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 Travis Shelly

Licensed Embalmer No. 2726

P. O. Address East Prairie M

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.