S. No. 2
M—9-4-41
v. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

22878

State File No.

FILED JUL 23 1945

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2941

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Research Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital ~~or institution~~ 20 (Specify whether
In this community 20 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 2
(If outside city or town limits, write "RURAL")

(d) Street No. 4104 Garfield 8
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Carolyn Betty Cox

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female

5. Color or race W

6. (a) Single, widowed, married, divorced Infant

6. (b) Name of husband or wife

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

7. Birth date of deceased 7 (Month) 1 (Day) 45 (Year)

8. AGE: Years | Months | Days | If less than one day hr. 20 min.

9. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country)

10. Usual occupation infant

11. Industry or business

FATHER
12. Name Walter E. Cox
13. Birthplace Greenwood (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Betty Nadine Huber
15. Birthplace Raymore (City, town, or county) Missouri (State or foreign country) O

16. (a) Informant Mrs. Walter Cox
(b) Address 4104 Garfield

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7-2-45 (Month) (Day) (Year)
(c) Place: ~~burial or~~ cremation Research Hospital

18. (a) Signature of funeral director Research Hospital
(b) Address K-C-Mo

19. (a) 7-14-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1st year 1945 hour 4:20 pm minute M.

21. I hereby certify that I attended the deceased from July 1 - 1945, 19, to, 19, that I last saw him alive on July 1, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death | Duration

Due to Malformations: Hydrocephalus - only one lung, 1/2 diaphragm, heart on

Due to right side. Premature 6 1/2 mos.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 157a

Of autopsy 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 Don Carlos Guppey, M.D. (M. D. or other)

Address 717 Prop Bldg Date signed 7/8/45

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(Licensed Embalmer's Statement on Reverse Side)

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.....

P. O. Address.....

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.