

FILED SEP 20 1945

State File No. _____

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 242

1. PLACE OF DEATH:

(a) County Marion Co.

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

(c) Name of hospital or institution:
Levering Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

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

(d) Street No. 2208 Hope
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME HENRY F. COX

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18th
year 1945 hour 3 minute 25 P.M.

21. I hereby certify that I attended the deceased from August 15,
1945, to August 18, 1945;
that I last saw him alive on August 18, 1945;
and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Jan. 20 - 1943
(Month) (Day) (Year)

Immediate cause of death	Duration
<u>Cerebral apoplexy</u>	<u>3 days</u>
Due to <u>Hypertension</u>	<u>2 yrs</u>
Due to <u>Arteriosclerosis</u>	<u>10 yrs</u>

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

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

82 6 29 hr. min.

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Jessie Cox

13. Birthplace Pa. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Jessie Turner

15. Birthplace Pa. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. P. H. Mosley

(b) Address Hannibal Mo.

17. (c) Burial (b) Date thereof Aug. 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wheeler

18. (a) Signature of funeral director Wm. P. H. Mosley

(b) Address Mexico, Mo.

19. (a) 8-22-45 (b) Dr. G. M. Lucke
(Date received local registrar) (Registrar's signature)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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 Fredrick B. Spencer, M.D. (M.D. or other)

Address 1948 Markt Hannibal, Mo. Date signed 8/21/45

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

4
3
4

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. 1-3499

P. O. Address Hannibal 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.