

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Registration District No. 27 Primary Registration District No. 3009 State File No. \_\_\_\_\_ Registrar's No. 17

1. PLACE OF DEATH:  
(a) County Bates  
(b) City or town Butler  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
310 West Fort Scott /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Butler, 17 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Bates 7  
(c) City or town Butler /  
(If outside city or town limits, write "RURAL")  
(d) Street No. 310 W Fort Scott /  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Benjamin Franklin Cox  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex M 0 5. Color or race W  
6. (a) Single, widowed, married, divorced M 1  
6. (b) Name of husband or wife Eliza Ellen Cox 6. (c) Age of husband or wife if alive 84 years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 29  
year 1946 hour 6 minute P. M.  
21. I hereby certify that I attended the deceased from June 1929 to Jan 29 1946  
that I last saw him alive on Jan 29 1946  
and that death occurred on the date and hour stated above.

7. Birth date of deceased: August 18, 1858  
(Month) (Day) (Year)  
8. AGE: Years 87 Months 5 Days 11  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death: Broncho pneumonia  
Due to Infection  
Due to \_\_\_\_\_

9. Birthplace no record Illinois  
(City, town, or county) (State or foreign country)  
10. Usual occupation Retired Railroad man

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name J. Henry Cox  
13. Birthplace no record 9  
(City, town, or county) (State or foreign country)  
14. Maiden name no record  
15. Birthplace no record 9  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
33/5

16. (a) Informant Ellen N. McCullough  
(b) Address Butler, Missouri  
17. (a) Burial (b) Date thereof Jan. 31/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation Union Cemetery  
St. Louis City, Mo  
18. (a) Signature of funeral director Curver-Underwood  
(b) Address Butler, Missouri  
19. (a) 1-30-46 (b) Randall Perry  
(Date received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_  
(c) Means of injury \_\_\_\_\_  
23. Signature L. D. Lathrop (M.D. or other) \_\_\_\_\_  
Address Butler, Mo Date signed 1-30-46

019 WHITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 *John G. Anderson*  
Licensed Embalmer No. *3585*  
P. O. Address. *Butler Ind*

**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.**