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FILED JAN 21 1946  
Registration District No. 238

Primary Registration District No. 5823

State File No. ....

Registrar's No. 115

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town New Madrid, Township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: NO  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution NO  
In this community all of life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
(c) City or town New Madrid  
(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 Vernon Theodore Cox

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex M 5. Color or race W. 6. (a) Single, widowed, married, divorced C.

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive ✓ years (Day) (Year)

7. Birth date of deceased May 21 1929  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
16 7 15 ..hr. ....min.

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

10. Usual occupation School

11. Industry or business ✓

12. Name Willie T. Cox

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

14. Maiden name Lillian Rose

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

16. (a) Informant Lillian B. Cox

(b) Address New Madrid, Mo.

17. (a) Burial (b) Date thereof 1-7-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dikeston

18. (a) Signature of funeral director Richards and Co.  
(b) Address New Madrid, Mo.

19. (a) 1-7-46 (b) Edw. Louis Jones  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5  
year 1946 hour 3:30 minute P.M.

21. I hereby certify that I attended the deceased from .....  
..... 19....., to ..... 19.....;  
that I last saw h..... alive on....., 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hit by train  
at New Madrid Crushed  
body

Due to body  
Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: Of operations .....  
Of autopsy .....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Accident

(b) Date of occurrence Jan 5 - 1946

(c) Where did injury occur? New Madrid, Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Place  
(Specify type of place)

While at work? ✓ (e) Means of injury.....

23. Signature Edw. Louis Jones (M., D. or other)  
Address New Madrid, Mo. Date signed 1-6-46

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

RECEIVED

District Health Office No. 2,

District File Number 146-95

Date Filed 1-11-46

**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.**

Registration District No. 238

Primary Registration District No. 5823

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(b) City or town New Madrid sup  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Vernon Theodore Cox

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m. 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased May 2 1921  
(Month) (Day) (Year)

8. AGE: Years 16 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day) hr. \_\_\_\_\_ 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 \_\_\_\_\_ year 1946 hour 9 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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 car used hit by train

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 \_\_\_\_\_

1640 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

3445