

No. 2
5-42
17-39
X32873

FILED **1946**

Registration District No. **21528** Primary Registration District No. **5823**

Registrar's No. **117**

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution: No 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community all of life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Kewanee
(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 Willie T. Cox

3. (b) If veteran, name war No

3. (c) Social Security No. 492-1643

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 him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife William B. Cox 6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased Sept. 8 1903
(Month) (Day) (Year)

Immediate cause of death: Hit by Frisco train at Kewanee, crushed

Due to hwy

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

| 8. AGE: | Years | Months | Days | If less than one day |
|-----------|----------|-----------|-------|----------------------|
| <u>42</u> | <u>3</u> | <u>28</u> | _____ | _____ hr. _____ min. |

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Farming

11. Industry or business _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations _____

Of autopsy _____

12. Name Albert Cox

13. Birthplace Waverling Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Jones

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

16. (a) Informant Lucille B. Cox

(b) Address Kewanee Mo.

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

(c) Place: burial or cremation Reston, Mo.

18. (a) Signature of funeral director Richard W. D. Co

(b) Address New Madrid Mo.

19. (a) 1-7-46 (b) Richard W. D. Co
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 72

(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 Leo H. H. Smith (M.D. or other)
Address New Madrid Mo. Date signed 1-6-46

RECEIVED

District Health Office No. 2,

District File Number 146-97

Date Filed 1-11-46

L. H. SOID

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 Leo H. Smith
Licensed Embalmer No. 3803
P. O. Address New Madrid

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 117

Registration District No. 238

Primary Registration District No. 5823

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town New Madrid
(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 _____ years, months or days

3. (a) PRINT FULL NAME Willie J. 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 m

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

7. Birth date of deceased Sept 8 (Month) (Day) (Year)

8. AGE: Years 42 Months 3 Days 8 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 _____

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)

(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) _____ 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 _____

Due to Heart Cox was hit by train

Due to _____

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

Major findings: Of operations MO 23
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) _____
(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 _____

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

SUPPLEMENTARY

3446