S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 2 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 20211

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2664

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: Osteopathic Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 hours (Specify whether
In this community 40 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 205 East 33rd Street 8
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country x

3. (a) PRINT FULL NAME Ralph Edwin Cozad

3. (b) If veteran, name war no.

3. (c) Social Security No. 495-05-2673 a

4. Sex male 0

5. Color or race white

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

6. (b) Name of husband or wife Daisy Annette Cozad

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased September (Month) 4 (Day) 1877 (Year)

8. AGE: Years 68 Months 9 Days ~~12~~ 11 If less than one day hr. min.

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

10. Usual occupation Salesman

11. Industry or business x

FATHER
12. Name Joseph Cozad
13. Birthplace unknown, 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Vanderbeck
15. Birthplace unknown, 6 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Daisy Annette Cozad
(b) Address 205 E. 33, Kansas City, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 6-18-46 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 6-17-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 15 year 1946 hour 4:00 minute p M.

21. I hereby certify that I attended the deceased from Coroner, 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 Fracture Right Femur & Pelvis

Due to Shock

Due to

Other conditions (Include pregnancy within 3 months of death) 186 a 5 18

Major findings:
Of operations

Of autopsy no History & Inspection

Duration

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 123
(b) Date of occurrence 6-15-46
(c) Where did injury occur? K.C. Jackson Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? about Home (Specify type of place)
While at work? no (e) Means of injury Fall

23. Signature James Walker (M. D. ~~or other~~) 3
Address 1424 prof Bldg Date signed 6-16-46

(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. 1415

P. O. Address K. C., 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.