S. No. 2
M—8-43
. 5-17-39
J X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 1 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 33344

Registration District No. 137 Primary Registration District No. 2023 Registrar's No. 203

1. **PLACE OF DEATH:**
(a) County Henry
(b) City or town Clinton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Westmel Hospital (If not in hospital or institution, write street address or location)
(d) Length of stay: In hospital or institution 19 days (Specify whether
In this community 19 days years, months or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County St Clair
(c) City or town Jamesy City Mo (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location) 1
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Iris Celia Cox
3. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex F | 5. Color or race Wh | 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Earl Cox
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 1 (Day) 1905 (Year)

8. AGE: Years 41 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace St Clair Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

MOTHER FATHER
12. Name William R. Sherman
13. Birthplace St Clair Co. (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name Jane Stewart
15. Birthplace (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Grace Ward
(b) Address Jamesy City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-46 (Month) (Day) (Year)
(c) Place: burial or cremation Jamesy City Cem
18. (a) Signature of funeral director Osceola Funeral Home
(b) Address Osceola Mo
19. (a) 10-25-46 (Date received local registrar) (b) R R Kennedy (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month October day 25th
year 1946 hour 3 minute 35 P. M.

21. I hereby certify that I attended the deceased from 3-15, 1946 to 10-25, 1946 that I last saw her alive on October 25, 1946; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Paralytic ileus	9 days.
Due to: intussusception	12 hrs.
Due to: post operative - (to Salpingectomy)	10 days
Other conditions (Include pregnancy within 3 months of death)	post operative

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature R. J. Terrell (M. D. or other)
Address Clinton Mo Date signed 10/25/46

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 71
District File Number 9-4-6-3-69
Date Filed 10-28-45

NOV 2 1950

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 Paul Funeral

Licensed Embalmer No. 3990

P. O. Address Ocala Fla.

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.