

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 27 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1034**
Registrar's No. **171**

Registration District No. **149** Primary Registration District No. **1002**

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:
3515 Wyandotte Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **33 1/2 1/2 Months** years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **3515 Wyandotte Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mrs Emily Ellen Cox**
(b) If veteran, name war **No**
(c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Jan**, day **13th**
year **1947** hour **9** minute **50 P.** M.

4. Sex **Female** / 5. Color or race **White**
6. (a) Single, widowed, married, divorced. **Married**
6. (b) Name of husband or wife **W. A. Cox**
6. (c) Age of husband or wife if alive **75** years
7. Birth date of deceased **July 26 1867**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **9/23/46** to **1/13/47**
that I last saw her alive on **1/13/47**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
78 79 5 17 hr. min.

Immediate cause of death **Myocardial Infarction and Failure**
Due to **Pulmonary edema**
Due to **Generalized induration and fibril dementia**
Other conditions (Include pregnancy within 3 months of death) _____
Duration _____

9. Birthplace **Dont Know** (City, town, or county) (State or foreign country)
10. Usual occupation **At Home**

PHYSICIAN
Major findings: Of operations **93e**
Of autopsy _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business _____
12. Name **Dont Know**
13. Birthplace **Dont Know** (City, town, or county) (State or foreign country)
14. Maiden name **Dont Know**
15. Birthplace **Dont Know** (City, town, or county) (State or foreign country)

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 **Dr. J. Stephens** (M. D. or other) _____
Address **3. E. 39th N. C. No.** Date signed **1/14/47**

16. (a) Informant **Mrs. Orville O'Dell**
(b) Address **3515 Wyandotte Street**
17. (a) **Burial** (b) Date thereof **1/15/47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Stockton, Missouri**
18. (a) Signature of funeral director **Freeman Mortuary**
(b) Address **Kansas City, Missouri**
19. (a) **1-14-47** (b) **Thereldine Holmes**
(Date received local registrar) (Registrar's signature)

WRITE 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 Oliver C. Wedelir
Licensed Embalmer No. 3495
P. O. Address N. 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.

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W. C. Wedelir
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