

No. 2
-12-45
5-17-39
PI X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12359**
Registrar's No. **63**

Registration District No. **18** Primary Registration District No. **3002**

1. PLACE OF DEATH:
(a) County **Audrain**
(b) City or town **Mexico**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Audrain Co. Hospital
(If not in hospital or institution, write street number or location)
7 weeks
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **State** **7 weeks**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Audrain**
(c) City or town **Vandalia**
(If outside city or town limits, write "RURAL")
(d) Street No. **301 E. State**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Charles A. Cox**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **488-30-9162**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **4** day **13**
year **1947** hour **2:35** minute **P** M.

4. Sex **M** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **Rose M. Nolte Cox** 6. (c) Age of husband or wife if alive **56** years
7. Birth date of deceased **Feb. 5, 1878**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **9-22-46** to **4-4-47**
that I last saw him alive on **4-13-47**
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral edema.
Due to **Hypertension**
Due to _____
Other conditions **Abdominal ascites**
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER FATHER

8. AGE: Years Months Days If less than one day
69 **2** **8** hr. min.
9. Birthplace **Osage Co., Mo.**
(City, town, or county) (State or foreign country)
10. Usual occupation **stationary engraver**
11. Industry or business _____

12. Name **Thomas J Cox**
13. Birthplace **Osage Co., Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Cooper**
15. Birthplace **Osage Co., Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Chas. Cox**
(b) Address **Vandalia, Mo.**
17. (a) **Burial** (b) Date thereof **April 15, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Anderson Cem. Osage**
18. (a) Signature of funeral director **Wm B. Winters**
(b) Address **Vandalia, Mo.**
19. (a) **4/15/47** (b) **Blanche Kelly**
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations _____
Of autopsy **124 B**

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? **CO**
(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature **Frank Deley** (M. D. or other) **764**
Address **Vandalia, Mo.** Date signed **4/15/47**

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

MAY 8 1947

RECEIVED
District Health Officer No. 10
District File Number 4-47-697
Date Filed APR 22 1947

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. 4169

P. O. Address..... Vandelin 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.

4/11/47
4/11/47
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