

Registration District No. **FILED OCT 21 1947**

Primary Registration District No. **1002**

1. PLACE OF DEATH: **Jackson**

(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: **General Hospital No. 1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: **10 days**
(Specify whether)

In this community: **3 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **Jackson** **48**

(c) City or town: **Kansas City** **2**
(If outside city or town limits, write "RURAL")

(d) Street No.: **4148 Warwick** **8**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country: _____

3. (a) PRINT FULL NAME: **Mildred Cox**

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

489 Social Security No. **unknown**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **10** year **1947** hour **10** minute **30 A.M.**

4. Sex: **female** 5. Color or race: **white**

6. (a) 'Single, widowed, married, divorced, **unk.**

6. (b) Name of husband or wife: **unknown** 6. (c) Age of husband or wife if alive: **unk.** years

7. Birth date of deceased: **February 26, 1902**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Oct. 1, 1947**, to **Oct. 10, 1947**, that I last saw her alive on **Oct. 10, 1947**, and that death occurred on the date and hour stated above.

Duration

8. AGE:	Years	Months	Days	If less than one day
	45	7	14	br. min.

Immediate cause of death: **Bilateral pulmonary tuberculosis and abscesses**

Due to: _____

Due to: _____

Other conditions: **13 b.**
(Include pregnancy within 3 months of death)

9. Birthplace: **Johnson Co., Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation: **adjuster**

11. Industry or business: **Sears-Roebuck**

12. Name: **Ephram A. Davis**

13. Birthplace: **Elizabeth Pennsylvania**
(City, town, or county) (State or foreign country)

14. Maiden name: **Alice Caldwell**

15. Birthplace: **Dork Co., Ohio**
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations: _____

Of autopsy: **See above**

PHYSICIAN

Underline the cause of which death should be charged statistically.

16. (a) Informant: **Mary K. Davis**
(b) Address: **Warrensburg, Mo.**

17. (a) **Burial** (b) Date thereof: **10-12-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Warrensburg, Mo.**

18. (a) Signature of funeral director: **H.A. Brauning**
(b) Address: **Warrensburg, Mo.**

19. (a) **10-10-47** (b) **Geraldine Holmes**
(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): _____

(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: **Wm. H. Hart** (M. D. or other) **MD**
Address: **Med. Dir. Gen'l Hosp.** Date signed: **10-10-47**

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

MOTHER FATHER

Dr. McDonald
8761, 2, 1948

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. 3377

P. O. Address Warrensburg, 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.

FILED NOV 4 1947/49

Registration District No.

Primary Registration District No.

Registrar's No.

4270

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: St. Hosp. # 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 _____
years, months or days

3. (a) PRINT FULL NAME

Mildred Cox

3. (b) If veteran, name war _____

3. (c) Social Security No. 489-22-6545

4. Sex _____ 5. Color or race _____

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

6. (b) Name of husband or wife Edward R. Cox

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

7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) 10-10-47 (b) Seraldine Holm
(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 Oct Day 10 Year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

S-34424