No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

40913

State File No. .....

Registration District No. FILED JAN 12 1948 42

Primary Registration District No. 1000

Registrar's No. 1545

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2018 Francis St. Rosery Hill Nursing Home.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 11 months. (Specify whether years, months or days)

In this community: 65 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri. (b) County: Buchanan

(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No.: 2018 Francis Street
(If rural, give location)
No

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME: SONORA B. COX

3. (b) If veteran, name war: NO

3. (c) Social Security No.: NONE

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: WIDOW

6. (b) Name of husband or wife: Lewis H. Cox.

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

7. Birth date of deceased: January (Month) 5th. (Day) 1855 (Year)

8. AGE:

Years	Months	Days	If less than one day
92	10	23	....hr. ....min.

9. Birthplace: Sacramento, California. (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife.

11. Industry or business: HOME

FATHER
12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Welfare Board Records.
(b) Address: St. Joseph, Missouri.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 11/29th. 1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Memorial Park Cemetery

18. (a) Signature of funeral director: Mrs. E. R. Siderfaden
(b) Address: 602 South 10th. St. St. Joseph

19. (a) 1-2-48 (Date received local registrar) (b) E. L. Jenkins (Registrar's signature) 382

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov. day: 28th. year: 1947 hour: 4 minute: 45 PM M.

21. I hereby certify that I attended the deceased from January 23, 1947, to November 28, 1947 and that I last saw her alive on November 18, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Aortic Regurgitation	6 mos.
Due to: Arteriosclerosis	15 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN

Underline the cause of 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: G. H. Werner (M. D. or other) 11-29-1947

Address: Kirkpatrick Bldg. Date signed

St. Joseph, Mo.

Jefferson City Printing Co. (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 Mollie E. Sidenfaden Fox

Licensed Embalmer No. 4235

P. O. Address St. Joseph, 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.