

FEDERAL SECURITY AGENCY  
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **27613**  
Registrar's No. **7267**

Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **ST LOUIS**  
(b) City or town **ST LOUIS**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **MISSOURI PACIFIC HOSP. O**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **23 HOURS**  
(Specify whether years, months or days)  
In this community

3. (a) PRINT FULL NAME **Lafayette Calsen COX**

3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex **Male** 5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Married**  
(b) Name of husband or wife **Burta**  
6. (c) Age of husband or wife if alive **68** years  
7. Birth date of deceased **November 14, 1876**  
(Month) (Day) (Year)

8. AGE: Years **71** Months **9** Days **4**  
If less than one day hr. min.

9. Birthplace **St. Louis, Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired R.R. Clerk**

11. Industry or business

12. Name **Jacob Cox**

13. Birthplace **Va.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Anna**

15. Birthplace **Germany**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Burta Cox**

(b) Address **2841 Nebraska Ave.**

17. (a) **Burial** (b) Date thereof **8-20-1948**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine Cemetery**

18. (a) Signature of funeral director **Jay B. Smith**

(b) Address **7456 Manchester Rd.**

19. (a) **AUG 19 1948** (b) **J. T. Brudeck**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St Louis**  
(c) City or town **ST LOUIS**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2841 Nebraska**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **18**  
year **1948** hour **9** minute **10 A.M.**

21. I hereby certify that I attended the deceased from **Feb 15**  
1944 to **Aug 18** 1948  
that I last saw him alive on **Aug 18** 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **2 days**  
**Hypertension** **5 years**

Due to **832**  
Other conditions (Include pregnancy within 3 months of death)

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 **W. P. Schuler** (M.D. or other)

Address **W. P. Schuler** Date signed **8/18**

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

MOTHER FATHER

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**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. 4029

P. O. Address. Maplewood

**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.**