

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2357

BIRTH NO. _____ REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 6060 Registrar's No. 5

93
0
D

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

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Washington		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION R. 1 Stockton, Mo.		R. 1, Stockton, Mo.	

3. NAME OF DECEASED (Type or Print) a. (First) George	b. (Middle) S.	c. (Last) Cox	4. DATE OF DEATH (Month) (Day) (Year) Jan. 26, 1949
---	-----------------------	----------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 17, 1862	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
--------------------	-------------------------------	---	---------------------------------------	---	---------------------------	--------------------------	--------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? 0
---	--	---	---------------------------------------

13a. FATHER'S NAME Thompson S. Cox	13b. MOTHER'S MAIDEN NAME Mary Chamness	14. NAME OF HUSBAND OR WIFE Daisy Cox
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S SIGNATURE OR NAME Mrs. Daisy Cox, Stockton, Mo., Route 1	ADDRESS
--	--	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CHRONIC MYOCARDITIS		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) X DUE TO (c) X		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4222			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? :
--	--	------------------------------

22. I hereby certify that I attended the deceased from **Oct. 22, 1948**, to **JAN 26, 1949**, that I last saw the deceased alive on **Jan 17, 1949**, and that death occurred at **2 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE D. E. D. Brown (Degree or title) 2 DO.	23b. ADDRESS Callins Mo	23c. DATE SIGNED Jan 21 1949
---	--------------------------------	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 29, 1949	24c. NAME OF CEMETERY OR CREMATORY Witt Cemetery	24d. LOCATION (City, town, or county) St. Clair Missouri
---	--------------------------------	---	---

DATE REC'D BY LOCAL REG. Feb 2, 1949	REGISTRAR'S SIGNATURE Ruth Seewers	25. FUNERAL DIRECTOR'S SIGNATURE Winn Caratheo	ADDRESS Edwards Spg Mo
---	---	---	-------------------------------

RECEIVED
District Health Officer No. 7,
District File Number 1-49-51
Date Filed 2-11-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed: Hayden C. Crother

Licensed Embalmer No. 4419

P. O. Address El Dorado Springs, 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.