

BIRTH NO. 300 REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. 6029 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>Reynolds</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Reynolds</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sogan</u> c. LENGTH OF STAY (In this place) <u>life time</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>98</u> OR TOWN <u>rural Sogan</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Edward Fox</u>		d. STREET ADDRESS (If rural, give location) <u>rural, Sogan</u>	

3. NAME OF DECEASED (Type or Print) Edward Fox

a. (First) \_\_\_\_\_ b. (Middle) \_\_\_\_\_ c. (Last) Fox

4. DATE OF DEATH (Month) (Day) (Year) June 1 1949

5. SEX Male 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH Sept 16, 1866 9. AGE (In years last birthday) 83 Months 3 Days 14 Hours 0 If under 12 hrs. Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer 10b. KIND OF BUSINESS OR INDUSTRY retired farmer 11. BIRTHPLACE (State or foreign country) Reynolds Co. Mo 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Josiah Fox 13b. MOTHER'S MAIDEN NAME Vivie Harris 14. NAME OF HUSBAND OR WIFE 0

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) \_\_\_\_\_ 16. SOCIAL SECURITY NO. 00 17. INFORMANT'S SIGNATURE OR NAME Ed Harris, Reynolds, Mo. ADDRESS \_\_\_\_\_

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Bright's disease & INTERVAL BETWEEN ONSET AND DEATH unknown

ANTECEDENT CAUSES DUE TO (b) Artemic poisoning

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) \_\_\_\_\_

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Artemic poisoning no

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION 0 20. AUTOPSY? YES  NO

21a. ACCIDENT (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) \_\_\_\_\_ 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR \_\_\_\_\_

22. I hereby certify that I attended the deceased from May 31, 1949 to June 1, 1949, that I last saw the deceased alive on May 31, 1949 and that death occurred at 1 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) A. H. Bugg, M.D. 23b. ADDRESS Ellington, Mo 23c. DATE SIGNED 6-1-1949

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 24b. DATE June 4, 1949 24c. NAME OF CEMETERY OR CREMATORY Southuff cemetery 24d. LOCATION (City, town, or county) (State) Near Ellington Mo

DATE REC'D BY LOCAL REG. June 1-49 REGISTRAR'S SIGNATURE Essie Evans 25. FUNERAL DIRECTOR'S SIGNATURE Friends of Family ADDRESS \_\_\_\_\_

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

RECEIVED 6/10/49  
District Health Officer No. 5,  
District File Number 649443  
Date Filed 6/16/49

**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.

Signed \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.

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