

FILED JUL 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 22218
Registrar's No. 133

BIRTH NO. _____		REG. DIST. NO. 325		PRIMARY REG. DIST. NO. 3072		Registrar's No. 133		
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall, Mo.</u>				c. LENGTH OF STAY (in this place) _____				
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u>				d. STREET ADDRESS (If rural, give location) <u>R.F.D. 3</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fitzgibbons Hospital</u>								
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>R.</u> c. (Last) <u>Cox</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 28 1949</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 30-1894</u>		
9. AGE (In years last birthday) <u>55</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>28</u>		IF UNDER 1 HR. Hours <u></u> Min. <u></u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Operated Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Marshall, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Samuel G. Cox</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Ellen Price</u>			14. NAME OF HUSBAND OR WIFE <u>Fannie McCoy</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. James R. Cox-Marshall, Missouri</u>				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Consolidation of Right Lung</u> <u>Pneumonia (Bacterial)</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>490X</u>	
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____ m.		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 <u>May 1</u> , 19 <u>49</u> , to <u>June 28</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>49</u> , and that death occurred at _____ m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>John R. Lawrence, M.D.</u>				23b. ADDRESS <u>W. Michael, Mo</u>		23c. DATE SIGNED <u>June 28-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>June 30, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Samuel Memorial</u>		24d. LOCATION (City, town, or county) (State) <u>Marshall - Missouri</u>		
DATE REC'D BY LOCAL REG. <u>June 29-1949</u>		REGISTRAR'S SIGNATURE <u>Edw. J. Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. Leslie Surrency Marshall, Miss.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED JUL 5

District Health Officer No. 8,

District File Number

Date Filed

7-8-49

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

J. Leola Surrency

Licensed Embalmer No. 3235

P. O. Address

Marshall, 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.