

FILED AUG 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22947

State File No.

BIRTH NO.		REG. DIST. NO. <u>98</u>		PRIMARY REG. DIST. NO. <u>4165</u>		Registrar's No. <u>71</u>	
1. PLACE OF DEATH a. COUNTY <u>Daviess</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gallatin</u>		c. LENGTH OF STAY (in this place) <u>4 Years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gallatin</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION ---				d. STREET ADDRESS (If rural, give location) ---			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Napoleon</u> b. (Middle) <u>Bonaparte</u> c. (Last) <u>Cox</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 27 1949</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Oct. 5 1872</u>	
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>22</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>General Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Lafayette Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Benjamin Franklin Cox</u>			13b. MOTHER'S MAIDEN NAME <u>Rosana Scott</u>		14. NAME OF HUSBAND OR WIFE <u>Sarah Ellen Cox</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Jaunita Dowell, Gallatin, Mo.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Heart Failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pronounced Arteriosclerosis</u> DUE TO (c) <u>for several months</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>293X</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>Jan 1946</u> , to <u>June 27, 1949</u> , that I last saw the deceased alive on <u>June 26, 1949</u> and that death occurred at <u>11:40</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u>				(Degree or title)		23b. ADDRESS <u>[Address]</u>	
23c. DATE SIGNED <u>6/30/49</u>		24a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-30-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Scotland Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Daviess County, Mo.</u>		DATE REC'D BY LOCAL REG. <u>7th July 1949</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hope Funeral Home Gallatin, Mo.</u>	

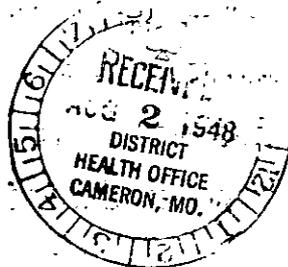
(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

3

W. J. W. Brown



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 _____

L. O. Richerson

Signed _____
Student Embalmer

Licensed Embalmer No. *3307*

P. O. Address *Fallston, Md*

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.