

FILED AUG 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27601

| | | | | |
|---|-------------------------------|---|--|--|
| BIRTH NO. | | REG. DIST. NO. 274 | PRIMARY REG. DIST. NO. 3052 | Registrar's No. 279 |
| 1. PLACE OF DEATH a. COUNTY <u>PETTIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>PETTIS</u> | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SEDALIA</u> | | c. LENGTH OF STAY (in this place) <u>2 yr</u> | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>303 E. BOONVILLE</u> | | d. STREET ADDRESS (If rural, give location) <u>415 E. JACKSON</u> | | |
| 3. NAME OF DECEASED (Type or Print) | | a. (First) <u>JOHN</u> | b. (Middle) <u>CALVIN</u> | c. (Last) <u>COX</u> |
| 4. DATE OF DEATH | | 4. DATE (Month) (Day) (Year) <u>AUG. 17 1949</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>MAY 28 - 1881</u> | 9. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u> IF UNDER 12 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>CLAY CO. MO. A</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | |
| 13a. FATHER'S NAME <u>SAMUEL J. COX</u> | | 13b. MOTHER'S MAIDEN NAME <u>JENNIE KINDRED</u> | | 14. NAME OF HUSBAND OR WIFE <u>JENNIE GRENSTED</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>JENNIE COX SEDALIA, 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION | | |
| | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u> | | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Coronary sclerosis</u> | | |
| | | DUE TO (c) <u>myocarditis, chronic</u> | | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | |
| 19c. INTERVAL BETWEEN ONSET AND DEATH <u>4201</u> | | | | |
| 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) | | 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>June 15, 1949</u> , to <u>Aug 17, 1949</u> , that I last saw the deceased alive on <u>Aug 17, 1949</u> , and that death occurred at <u>3:45 P. M.</u> , from the causes and on the date stated above. | | | | |
| 23a. SIGNATURE (Degree or title) <u>Chas. Hamilton Stanfield M.D.</u> | | 23b. ADDRESS <u>Sedalia Missouri</u> | | 23c. DATE SIGNED <u>Aug 17 - 49</u> |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 24b. DATE <u>AUG. 17 1949</u> | | 24c. NAME OF CEMETERY OR CREMATORY. <u>VERSAILLES, MO.</u> |
| 24d. LOCATION (City, town, or county) (State) <u>VERSAILLES, MO.</u> | | | | |
| DATE REC'D BY LOCAL REG. <u>8-17-49</u> | | REGISTRAR'S SIGNATURE <u>Betty Yeager</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. F. Kimmel VERSAILLES, MO.</u> |

RECEIVED AUG 22

District Health Officer No. 8,

District File Number _____

Date Filed 8-24-49

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 _____
Student Embalmer

Signed

Raymond C. Foster

Licensed Embalmer No. 4626

P. O. Address Versailles, 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.