

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29182

BIRTH NO. _____		REG. DIST. NO. <u>4</u>		PRIMARY REG. DIST. NO. <u>5029</u>		Registrar's No. <u>43</u>	
1. PLACE OF DEATH a. COUNTY <u>Atchison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Iowa</u> b. COUNTY <u>Fremont</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Lincoln</u>		c. LENGTH OF STAY (In this place) <u>2 hrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>6 Mi. SW of Northboro</u>		d. STREET ADDRESS (If rural, give location) <u>13</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5 Th NW of Weathers</u>				d. STREET ADDRESS (If rural, give location) <u>13</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>LLOYDE</u>		b. (Middle) <u>ALLEN</u>		c. (Last) <u>COX</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. - 17 - 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>January 5, 1925</u>	
9. AGE (In years last birthday) <u>24</u>		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		9. AGE (In years last birthday) <u>8</u> Months <u>17</u> Days	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Cecil Cox</u>		13b. MOTHER'S MAIDEN NAME <u>Eva Mae Jackson</u>		14. NAME OF HUSBAND OR WIFE <u>Frances Cox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Cecil E. Cox</u> ADDRESS <u>Northboro</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) _____						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
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 _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Suicide</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>South of Barn atchison high farm</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Atchison Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Sept 17, 1949 10:30 pm</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Self Inflicted</u>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Allen Peters 3rd coroner</u>				23b. ADDRESS <u>Fairfax Mo</u>		23c. DATE SIGNED <u>9/17/49</u>	
24a. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Sept-20-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Shenandoah, Iowa</u>	
DATE REC'D BY LOCAL REG. <u>Sept 20 49</u>		REGISTRAR'S SIGNATURE <u>Det. C. S. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arvid ...</u> ADDRESS <u>Weathers Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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



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 _____

Scott Tucker

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed Scott Tucker

Licensed Embalmer No. 2824

P. O. Address Westboro, Missouri

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.