

S. No. 300  
V. 10.48

FILED SEP 2 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27961

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 State File No. 3454 Registrar's No. 283

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>	
b. CITY OR TOWN <b>Farmington</b> <b>RURAL</b>		c. CITY OR TOWN <b>Bernie</b>	
c. LENGTH OF STAY (in this place) <b>St. Francois</b>		d. STREET ADDRESS (If rural, give location) <b>1030</b> <b>1</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Missouri State Hospital No. 4</b>			

3. NAME OF DECEASED (Type or Print) <b>WALTER</b>	a. (First)	b. (Middle)	c. (Last) <b>COX</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>August 24, 1950</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 3, 1882</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>21</b>	IF UNDER 4 HRS. Hours <b></b> Mins. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming and carpentry</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Jonesboro, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>William P. Cox</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Francis Boren</b>	14. NAME OF HUSBAND OR WIFE <b>Laura Jones</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>	16. SOCIAL SECURITY NO. <b>Unknown.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Records State Hospital No. 4, Farmington, Mo.</b>	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage - - - - -</b>		<b>Abt. a wk.</b>
	ANTECEDENT CAUSES DUE TO (b) <b>Hypertension - - - - -</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <b>Arteriosclerotic Heart Disease - -</b>		<b>10 Yrs.</b> <b>10Yrs.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<b>4200</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June 24, 1949, to August 24, 1950, that I last saw the deceased alive on August 24, 1950, and that death occurred at 10:55A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>John P. Brennan, M.D.</b>	23b. ADDRESS <b>State Hospital No. 4, Farmington, Mo.</b>	23c. DATE SIGNED <b>8-25-50.</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>AUG 27 1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bernie Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Bernie, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Aug. 25, 1950</b>	REGISTRAR'S SIGNATURE <b>Esther Rudolph</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Earl Watkins</b>	ADDRESS <b>Dexter</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0940

SEP 7 1950

File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4

AUG 29 1950

RECEIVED

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed *W. Cozart*

Licensed Embalmer No. *4004*

P. O. Address *Farmington, 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.