

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36269

State File No. _____

FILED NOV 14 1952

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. 9173

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 5 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jennings, 4138	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS (If rural, give location) 2648 Terrace Lane	

3. NAME OF DECEASED (Type or Print)	a. (First) Clifton	b. (Middle) Ray	c. (Last) Cox	4. DATE OF DEATH (Month) (Day) (Year) Oct. 2, 1952.
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH Apr. 30, 1878	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work denoting most of working life, even if retired) Comm. Photographer	10b. KIND OF BUSINESS OR INDUSTRY Photography	11. BIRTHPLACE (State or foreign country) Cranford, N. J. /	12. CITIZEN OF WHAT COUNTRY U. S.
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13a. FATHER'S NAME Stephen J. Cox	13b. MOTHER'S MAIDEN NAME Mary Ray	14. NAME OF HUSBAND OR WIFE Ida B. Cox
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO	16. SOCIAL SECURITY NO. ---	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charlotte Johnston, Jennings, Mo.
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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, asthenia, 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) Carcinoma of Pancreas		
	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 9/22/52	19b. MAJOR FINDINGS OF OPERATION Ca of head of pancreas - obstructing bile duct	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 157X
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22. I hereby certify that I attended the deceased from 8/29, 1952, to 10/2, 1952, that I last saw the deceased alive on 10/1, 1952, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thomas C. Kuebrich M.D.	23b. ADDRESS 9 th S. Elmer St. Ferguson Mo.	23c. DATE SIGNED 10/3/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Transit	24b. DATE 10/3/52	24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	24d. LOCATION (City, town, or county) (State) Westfield, N. J.
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DATE REC'D BY LOCAL REG. OCT 3 1952	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS White Chapel, Ferguson, Mo.
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *R. M. White*

Licensed Embalmer No. *3973*

P. O. Address *Ferguson*

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.