No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34914

BIRTH NO. FILED NOV 13 1953 REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 4003 Registrar's No. 368

1. PLACE OF DEATH
a. COUNTY: ADAIR
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): GIBBS
c. LENGTH OF STAY (In this place): 5 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): GIBBS Mo

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI b. COUNTY: ADAIR
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): GIBBS 0010 0
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): EDWARD b. (Middle): BYRON c. (Last): FOX

4. DATE OF DEATH (Month) (Day) (Year): OCT 8 1953

5. SEX: M O

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 1

8. DATE OF BIRTH: JULY 1 1879

9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RAILROAD FOREMAN

10b. KIND OF BUSINESS OR INDUSTRY: RAILROADING

11. BIRTHPLACE (State or foreign country): MISSOURI O

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: HENRY FOX

13b. MOTHER'S MAIDEN NAME: ELLA MARCH

14. NAME OF HUSBAND OR WIFE: ESTELLA ENGSTROM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE OR NAME: ESTELLA ENGSTROM FOX — ADDRESS: GIBBS Mo

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): cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

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: 332X

20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 8, 1953, *to* Oct. 8, 1953, *that I last saw the deceased alive on* Oct. 8, 1953, *and that death occurred at* 6:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harold D. [illegible] M.D.

23b. ADDRESS: La Plata Mo.

23c. DATE SIGNED: 10-8-53

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24b. DATE: OCT 10 1953

24c. NAME OF CEMETERY OR CREMATORY: BULLION

24d. LOCATION (City, town, or county) (State): 7 MI. W BRASHEAR MO

DATE REC'D BY LOCAL REG.: 11-12-53

REGISTRAR'S SIGNATURE: Kate Lambert 1-0

25. FUNERAL DIRECTOR'S SIGNATURE: Geo B Easly Jr. — ADDRESS: Kirkland Mo

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 6 1952

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 Geo B Easley Jr

Licensed Embalmer No. 3755

P. O. Address Hurdland M

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.