

FILED JUN 15 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15314**

BIRTH NO. _____		REG. DIST. NO. 77	PRIMARY REG. DIST. NO. 3016	Registrar's No. 159
1. PLACE OF DEATH a. COUNTY COLE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI 211 LAFAYETTE b. COUNTY COLE		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFFERSON CITY		c. LENGTH OF STAY (in this place) c. CITY OR TOWN JEFFERSON CITY		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION ST MARYS HOSPITAL		No. STREET ADDRESS (If rural, give location) 211 Lafayette		
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) Thomas c. (Last) Cox		4. DATE OF DEATH (Month) (Day) (Year) June 10 54		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 11-22-1878	
9. AGE (If years last birthday) 76		10. KIND OF BUSINESS OR INDUSTRY PRISON GUARD Mo. Prison	11. BIRTHPLACE (City and State or Foreign Country) Chilhowee Mo	12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME John Cox		13b. MOTHER'S MAIDEN NAME Sarah Flynn	14. NAME OF HUSBAND OR WIFE PEARL COX	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME Mrs Anna Clark ADDRESS Kansas City 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction ANTECEDENT CAUSES DUE TO (b) Coronary atherosclerosis DUE TO (c) arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 1 year 1 wk.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4201		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) m.		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 6/4 , 19 54 , to 6/10 , 19 54 , that I last saw the deceased alive on 6/10 , 19 54 and that death occurred at 3:00 p.m. , from the causes and on the date stated above.				
23a. SIGNATURE J. J. Canegawa (Degree or title) m.d.		23b. ADDRESS Dallmeyer Bldg		23c. DATE SIGNED 6/11/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	24b. DATE 6-13-54	24c. NAME OF CEMETERY OR CREMATORY Centerville Cemetery	24d. LOCATION (City, town, or county) (State) Mo.	
DATE REC'D BY LOCAL REG. June 12-54	REGISTRAR'S SIGNATURE R.P. Davis MD-NR	25. FUNERAL DIRECTOR'S SIGNATURE Anderson - Tanner		ADDRESS Jerm.

(Licensed Embalmer's Statement on Reverse Side)

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

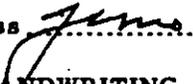
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 324

P. O. Address .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.