

FILED OCT 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35604

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 201

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall		c. LENGTH OF STAY (in this place) 1 day	c. CITY OR TOWN Malta Bend
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbon hospital		e. STREET ADDRESS (If rural, give location) Streets not numbered	

3. NAME OF DECEASED (Type or Print) **Floyd Cox**

a. (First) **Floyd** b. (Middle) **Cox** c. (Last) **Cox**

4. DATE OF DEATH **Oct. 17th, 1955**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **May 24th, 1870** 9. AGE (In years last birthday) **85**

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

10b. KIND OF BUSINESS OR INDUSTRY **Drug store**

11. BIRTHPLACE (City and State or Foreign Country) **Londonderry, Ohio.**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **John Cox** 13b. MOTHER'S MAIDEN NAME **Eliza Schneider** 14. NAME OF HUSBAND OR WIFE **Addie Cox**

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

16. SOCIAL SECURITY NO. **None**

17. INFORMANT'S SIGNATURE OR NAME **Miss Eleanor Cox, Hickman Mills, Mo.** ADDRESS **Hickman Mills, Mo.**

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Ruptured Aortic Aneurysm**

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.

INTERVAL BETWEEN ONSET AND DEATH **451X**

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____

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) _____ 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 **March, 1951**, to **Oct 17, 1955**, that I last saw the deceased alive on **Oct 17, 1955**, and that death occurred at **I.P.** m., from the causes and on the date stated above.

23a. SIGNATURE **James A. Reed M.D.** (Degree or title) 23b. ADDRESS **Marshall Mo** 23c. DATE SIGNED _____

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **Oct. 19, 1955** 24c. NAME OF CEMETERY OR CREMATORY **Malta Bend cemetery** 24d. LOCATION (City, town, or county) (State) **Malta Bend, Missouri**

DATE REC'D BY LOCAL REG. **Oct 19 - 55** REGISTRAR'S SIGNATURE **Cecil H. Reed** 385 DEPUTY CHIEF OF BUREAU **Campbell-Lewis** ADDRESS **MARSHALL, Mo.**

(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..... *James H. Lewis Jr.*

Licensed Embalmer No. *470*

P. O. Address *Marshall*

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.