

FILED JUL 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20550

BIRTH NO. _____		REG. DIST. NO. <u>98</u>		PRIMARY REG. DIST. NO. <u>4165</u>		Registrar's No. <u>68</u>			
1. PLACE OF DEATH a. COUNTY <u>Barren</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Grundy</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Gallatin</u>		c. LENGTH OF STAY (in this place) <u>3 mo.</u>		c. CITY OR TOWN <u>Salt</u>		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 <u>Juanita Rest Home</u>				e. STREET ADDRESS <u>0400</u> (If rural, give location)					
3. NAME OF DECEASED (Type or Print) <u>JOHN</u>			a. (First)		b. (Middle)		c. (Last) <u>COX</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>12-25-1867</u>		9. AGE (In years last birthday) <u>89</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. (Specify if required)) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Mo</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u> Peyton Cox</u>			13b. MOTHER'S MAIDEN NAME <u> Elizabeth Nash</u>			14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME <u> Alex Cox</u>				ADDRESS <u> Salt Mo</u>	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senile dementia</u>						INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <u>0</u> 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) <u>4221</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 <u>July 6, 1957</u> , to <u>July 6, 1957</u> that I last saw the deceased alive on <u>July 6, 1957</u> , and that death occurred at <u>2:40 a.m.</u> from the causes and on the date stated above.									
23a. SIGNATURE <u>W.B. Bailey</u> (Degree or title)				23b. ADDRESS <u>202 Jamesport Mo</u>		23c. DATE SIGNED <u>9-8-57</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7/10/57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Salt Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Salt Mo</u>			
DATE REC'D BY LOCAL REG. <u>7-10-57</u>		REGISTRAR'S SIGNATURE <u>Dequana M. English</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>P. K. Raymston Salt Mo</u>					

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD 4

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..... *PK Payne Jr*

Licensed Embalmer No. *340*

P. O. Address *Salt*

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.