

FILED NOV 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39241
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1212

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1802 S. 24th St.</u>		Length of stay in lb <u>35 yrs.</u>		d. STREET ADDRESS <u>1802 S. 24th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>May</u> Last <u>Cox</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>5</u> Year <u>1957</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1906</u>	9. AGE (In years from birthday) <u>50</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Henry County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>David Wesley Caselman</u>			13b. MOTHER'S MAIDEN NAME <u>Georgianna Crawford</u>			14. NAME OF HUSBAND OR WIFE <u>Rual G. Cox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Rual G. Cox, 1802 So. 24th St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC INSUFFICIENCY</u>						INTERVAL BETWEEN ONSET AND DEATH <u>when</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>LYMPHO SARCOMA - GENERALIZED.</u>						<u>when</u>	
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2001</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>2001</u>				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION			COUNTY _____ STATE _____
21. I attended the deceased from <u>5-9-57</u> to <u>11-5-57</u> and last saw ^{her} _{him} alive on <u>11-7-57</u> Death occurred at <u>7:30 a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Jed L Nelson MD</u>				22b. ADDRESS <u>902 Edmond</u>		22c. DATE SIGNED <u>11-6-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 7, 57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>		
24. FUNERAL DIRECTOR <u>Clark Funeral Home St. Joseph, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>Nov. 13, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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 *Emma Clark*

Licensed Embalmer No. *4238*

P. O. Address *St. Joseph 7*

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.