

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032609

STATE FILE NUMBER

FILED SEP 16 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4108

5. 300
1-57

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1		Length of stay in lb 16 Yrs	d. STREET ADDRESS (If outside, give location) 633 Brooklyn		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Jefferson Cox			4. DATE OF DEATH Month Day Year 8 26 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25 1900	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Road work	11. BIRTHPLACE (City and state or country) Keytesville, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John W. Cox		13b. MOTHER'S MAIDEN NAME Allie Grimsley		14. NAME OF HUSBAND OR WIFE Byda 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. 486-12-8781	17. INFORMANT Address Byda Cox (wife) 633 Brooklyn Kas. City, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					11/67
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <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 Aug. 26, 1958, to Aug. 26, 1958 and last saw him alive on Aug. 26, 1958 Death occurred at 11 P. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Red Burns, M.D.</i>			22b. ADDRESS 24th & Cherry		22c. DATE SIGNED 8-27-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Aug. 29 1958	23c. NAME OF CEMETERY OR CREMATORY Asbury		23d. LOCATION (City, town, or county) (State) Near- Keytesville, Missouri
24. FUNERAL DIRECTOR ADDRESS Mrs C.L. Forster Funeral Home Inc. 918 Brooklyn Kas. City, Mo.			25. DATE RECD. BY LOCAL REG. 8-28-58	26. REGISTRAR'S SIGNATURE <i>Neve Marshall</i>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

B. I. Burns



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 *J. Virgil Herrick*

Licensed Embalmer No. *3599*

P. O. Address *H. C. Mo...*

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.