

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036161  
STATE FILE NUMBER

FILED OCT 20 1958 Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 909

1. PLACE OF DEATH a. COUNTY <u>HENRY</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BENTON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLINTON</u>		Inside Limits. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>WARSAW</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>Left in Rest Home</u>		Length of stay in lb <u>2 months</u>	008d. STREET ADDRESS <u>WARSAW</u>		(If outside, give location). Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>COX</u> Last <u>COX</u>			4. DATE OF DEATH <u>Oct 14 1958</u> Month Day Year		
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>Feb 6, 1897</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> IF UNDER 24 HRS. Hours <u>7</u> Min.
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>Home</u>	11. BIRTHPLACE (City and state or country) <u>Warsaw, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>William E. Cox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>William E. Cox Warsaw, Mo</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>Acute Pulmonary Edema</u>					INTERVAL BETWEEN ONSET AND DEATH <u>One hour</u>
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. DUE TO (b) <u>Chronic arteriosclerotic myocarditis</u>					<u>2 years.</u>
DUE TO (c) <u>Pigeon disease</u>					<u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4221</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.)			
20c. TIME OF INJURY Hour a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>June 10, 1958</u> to <u>Oct 14, 1958</u> and last saw her alive on <u>Oct 14, 1958</u> Death occurred at <u>11:20</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Dr. R. S. Hallingman M.D.</u>			22b. ADDRESS <u>Clinton Missouri</u>		22c. DATE SIGNED <u>10/15/58</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 16, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moberly Cemetery</u>		23d. LOCATION (City, town, or county) <u>Moberly, Randolph, Mo</u>	
24. FUNERAL DIRECTOR <u>D.W. Newcommers</u>		ADDRESS <u>Kansas City, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-16-58</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 ..... *John J. Reser* .....

Licensed Embalmer No. *4098* .....

P. O. Address *Winn* .....

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.