

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005283

STATE FILE NUMBER

FILED FEB 24 1959

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 17

300
-57

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Plattsburg</u> ⁰²⁵⁰ 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>Noll Mem Hosp.</u>		Length of stay in lb <u>3 day</u>	d. STREET ADDRESS (If outside, give location) <u>do not know</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Bessie Ann Cox</u>			4. DATE OF DEATH Month Day Year <u>2-12-1959</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-26-1882</u>	9. AGE (In years last birthday) <u>76</u>	10. FUNDER 1 YEAR Months Days <u>9 16</u>	11. IF UNDER 24 HRS. Hours Min.
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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>—</u>	11. BIRTHPLACE (City and state or country) <u>Harrison County, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>James S. Magee</u>	13b. MOTHER'S MAIDEN NAME <u>Josephine Nelson</u>	14. NAME OF HUSBAND OR WIFE <u>Monroe Cox</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Arthur Cox Plattsburg Mo.</u>
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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>BRONCHIAL PNEUMONIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 d.</u> <u>years.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CHRONIC BRONCHIAL ASTHMA.</u>	
	DUE TO (c) <u>MIXED</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>MULTIPLE RIB FRACTURES.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input checked="" 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>Fell from bed at home on Feb 8th.</u>
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20c. TIME OF INJURY <u>8 a.m.</u> <u>2-8-59</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. CITY, TOWN, OR LOCATION <u>Plattsburg</u>	COUNTY <u>Clinton</u>	STATE <u>Mo.</u>
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21. I attended the deceased from <u>March '56</u> to <u>Feb. 12, '59</u> and last saw her alive on <u>Feb 12, 1959</u> Death occurred at <u>3:08 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Albert F. Nibbe M.D.</u>	(Degree or title)	22b. ADDRESS <u>Bethany Mo.</u>	22c. DATE SIGNED <u>2-16-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-14-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Morris Chapel</u>	23d. LOCATION (City, town, or county) (State) <u>Bethany Mo</u>
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24. FUNERAL DIRECTOR <u>McHann</u>	ADDRESS <u>Bethany Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-16-1959</u>	26. REGISTRAR'S SIGNATURE <u>Idella Masey</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *M.B. Jaas*

Licensed Embalmer No. *3899*

P. O. Address *Bethany, 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.