

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025862

FILED VS JUL 29 1959

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 192

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Livingston</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>17 yrs.</u>		c. CITY OR TOWN <u>Chillicothe</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>436 Jackson</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>436 Jackson</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Leslie</u> Last <u>Cox</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1959</u>					
5. SEX <u>male</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>11-11-76</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>real-estate broker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>John C. Cox</u>			13b. MOTHER'S MAIDEN NAME <u>Ammanda Squires</u>			14. NAME OF HUSBAND OR WIFE <u>Jessie A. Cox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>487-14-4412</u>		17. INFORMANT Address <u>Mrs. Jessie Cox, Chillicothe, 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>Pneumonia Terminal</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary sclerosis.</u>							2 yrs		
DUE TO (c) <u>Arterial sclerosis</u>							2 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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.		Month, Day, Year _____							
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 <u>June 1 - 55</u> to <u>July 20 - 55</u> and last saw him alive on <u>July 19 - 55</u>				Death occurred at <u>10:15</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree) or title <u>Joseph A. Conrad M.D.</u>				22b. ADDRESS <u>Chillicothe, Mo.</u>			22c. DATE SIGNED <u>July 21 - 59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>7-22-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood Cemetery</u>		23d. LOCATION (City, town, or county) <u>Chillicothe, Mo.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Normans Chillicothe, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7/21/59</u>		26. REGISTRAR'S SIGNATURE <u>Frances B Neill</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John J. Polini  
Licensed Embalmer No. 5035

P. O. Address Chillicothe

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.