

# FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED VS FEB 8 1960

#60-000845  
STATE FILE NUMBER

Registration District No. 93 Primary Registration District No. \_\_\_\_\_ Registrar's No. 66-10

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dade</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Dadeville</u> Length of stay in 1b <u>years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home, Dadeville</u> Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dade</u> c. CITY OR TOWN <u>Dadeville</u> Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Den. Del.</u> Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Cordis</u> Middle <u>Orvil</u> Last <u>Fox</u>			<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>1</u> Year <u>1960</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/11/1892</u>	<b>9. AGE (last birthday)</b> <u>67</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Dade County, Mo.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>	
<b>13a. FATHER'S NAME</b> <u>Bartley B. Fox</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Susana M. Pherson</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Claudia Fox</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			<b>16. SOCIAL SECURITY NO.</b> <u>490-28-2470</u>		<b>17. INFORMANT</b> Address <u>Mrs. Claudia Fox, Dadeville, Mo.</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO (b) <u>arteriosclerosis + generalised debility</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>years</u>	
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b> _____ <b>STATE</b> _____			
<b>21. I attended the deceased from</b> <u>7-23-57</u> to <u>2-1-60</u> and last saw <sup>her</sup> <u>him</u> live on <u>1-4-60</u> Death occurred at <u>3:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>E. M. Taylor, M.D.</u>				<b>22b. ADDRESS</b> <u>Rockwood, Mo</u>		<b>22c. DATE SIGNED</b> <u>2/3/60</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>Feb. 3, 1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Masonic Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Dadeville, Missouri</u>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Brim Daniel, Walnut Grove, Mo</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>2-5-1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>J. C. Canada</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 Ray E. Ireland

Licensed Embalmer No. 5052

P. O. Address Helms Grove

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.