

JR: DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002292

FILED VS JAN 12 1960

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 2

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Laclede				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Laclede					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lebanon		Length of stay in 1b 9 yrs.		c. CITY OR TOWN Lebanon		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Wallace Hospital			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Route #3		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John Leonard Cox				4. DATE OF DEATH Month January Day 1 Year 1960					
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 12-30-03	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M.F.A. Representative			10b. KIND OF BUSINESS OR INDUSTRY M.F.A.		11. BIRTHPLACE (City and state or country) Arkansas		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Elliott Cox			13b. MOTHER'S MAIDEN NAME Mary Smelser			14. NAME OF HUSBAND OR WIFE Tenna Cox			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no none			16. SOCIAL SECURITY NO. 498-28-8815		17. INFORMANT Address Mrs. Tenna Cox, Lebanon, 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) Cerebral Hemorrhage left with rt hemiplegia							INTERVAL BETWEEN ONSET AND DEATH 2 or 3 hrs.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic Degener. of Brain					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 checked="" 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 Supplement may be sent after Path report							
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 11-19 1958 to Jan. 1-1960 and last saw him alive on JAN. 1, 1960 Death occurred at 9:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Paul A. Jenkins MD (Degree or title)				22b. ADDRESS Knight Bldg., Lebanon, Mo.				22c. DATE SIGNED 1-8-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 1-4-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Rose Memorial Park			23d. LOCATION (City, town, or county) Lebanon, Missouri			
24. FUNERAL DIRECTOR J.P. Shadel ADDRESS Lebanon, Mo.			25. DATE RECD. BY LOCAL REG. 1-8-1960		26. REGISTRAR'S SIGNATURE Hella L. May				

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 Warren C. Simpson

Licensed Embalmer No. 5071

P. O. Address Hartwell, Md.

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.