

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-012368
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2504

AMENDED FILED JUN 5 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
Joseph A. Fogarty
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in lb 12 years		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Little Sisters Home		d. STREET ADDRESS (If outside, give location) 5331 Highland	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Floyd D. Cox			4. DATE OF DEATH Month Day Year May 20 1961
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 10-14-1893
9. AGE (last birthday) 67 years		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stockman		10b. KIND OF BUSINESS OR INDUSTRY Peters Serm.	
11. BIRTHPLACE (City and state or country) Lebanon, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Harvey Cox		13b. MOTHER'S MAIDEN NAME Lillie Carr, LI	
14. NAME OF HUSBAND OR WIFE Florence Cox		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs Florence Cox 3617 Main St., Apt. #1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Heart Disease		20 yrs.	
DUE TO (c)			
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 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 3/19/61 to 5/20/61 and last saw ^{the} him alive on 5/19/61 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree MD.) Joseph A. Fogarty	22b. ADDRESS 402 North Main St. #69 Mo.	22c. DATE SIGNED 5/22/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 23, 1961	23c. NAME OF CEMETERY OR CRYPTORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Hickman Mills, Mo.
24. FUNERAL DIRECTOR Thomas E. Quirk 701 East 63rd	25. DATE RECD. BY LOCAL REG. 5-22-61	26. REGISTRAR'S SIGNATURE Ruth Long	

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 _____

Licensed Embalmer No. 37

P. O. Address _____

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.