

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043827

STATE FILE NUMBER

AMENDED

Registration District No. 53 Primary Registration District No. 0000 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <u>CAPE GIRARDEAU</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CAPE GIRARDEAU</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Welch</u>		Length of stay in 1b	c. CITY OR TOWN <u>ADVANCE</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Route, ADVANCE, Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route</u>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>William Joseph Cox</u>			4. DATE OF DEATH Month Day Year <u>DEC. 26, 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-12-77</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>4 14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>Cape Girardeau Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>William Cox</u>		13b. MOTHER'S MAIDEN NAME <u>Not Known</u>		14. NAME OF HUSBAND OR WIFE <u>Not Known</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>loyd Cox, ADVANCE, Mo</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>		<u>3 months</u>
DUE TO (b) <u>Auricular Fibrillation</u>		<u>3 months</u>
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		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.			
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 December 1953 to Dec. 26, 1961 and last saw ^{him} alive on Dec. 26, 1961
Death occurred at 9:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Edward O Campbell</u>		22b. ADDRESS <u>M.D. Cape Girardeau, Missouri</u>	22c. DATE SIGNED <u>12-30-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-28-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MORGAN MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>ADVANCE Mo.</u>
24. FUNERAL DIRECTOR <u>W^{ms} H. Morgan</u>	ADDRESS <u>Advance, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>1-3-1962</u>	26. REGISTRAR'S SIGNATURE <u>Irene Kuster</u>

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 _____

Wm. H. Morgan

Licensed Embalmer No. *4640*

P. O. Address *Advance, N*

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.