

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-018641

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 761

FILED MAY 21 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Springfield | | c. CITY OR TOWN Springfield | |
| Length of stay in 1b | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital | | d. STREET ADDRESS (If outside, give location) 1225 W. Dale St. | |
| Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last COX | | | 4. DATE OF DEATH Month May Day 11 Year 1962 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 18 July 1879 |
| 9. AGE (last birthday) 82 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Dealer | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | 11. BIRTHPLACE (City and state or country) Missouri |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME W.D. Cox | |
| 13b. MOTHER'S MAIDEN NAME Sarah Thompson | | 14. NAME OF HUSBAND OR WIFE Deceased | |
| 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. <input type="checkbox"/> | |
| 17. INFORMANT Herman Cox (Son) | | Address 1173 Roanoke Springfield, Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) nephrosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Uremia DUE TO (b) Uremia 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 | | | INTERVAL BETWEEN ONSET AND DEATH sev. yrs sev. mo. |
| 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 <u>April 1962</u> to <u>5/11/62</u> and last saw ^{her} him alive on <u>5/11/62</u> Death occurred at <u>9:17</u> <u>A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>[Signature]</i> (Degree or title) M.D. | | 22b. ADDRESS 600 S. Glenstone Springfield, Missouri | 22c. DATE SIGNED 5-12-62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 5/14/62 | 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery | 23d. LOCATION (City, town, or county) (State) Springfield, Missouri |
| 24. FUNERAL DIRECTOR KLINGNER MORTUARY, INC. Springfield, Mo. | | 25. DATE RECD. BY LOCAL REG. 5-14-62 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

jhc

(Licensed Embalmer's Statement on Reverse Side)

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 John Kluszewski Jr.

Licensed Embalmer No. 5102

P. O. Address Springfield

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.

permit received 5-14-62