

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025036

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 337 Primary Registration District No. 477 Registrar's No. 15

STATE FILE NUMBER

FILED JUN 21 1963

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Macon		a. STATE Missouri COUNTY Shelby	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Macon		c. CITY OR TOWN Clarence	
Length of stay in 1b 40 Days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Samaritan Hospital		d. STREET ADDRESS (If outside, give location) Clarence	
Inside Limits Yes <input checked="" 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)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
Ernest Euclid Cox			5-2-1963		

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 12-10-1877	9. AGE (last birthday) 85	IF UNDER 1 YEAR	IF UNDER 24 HR
			Months 45	Days 22	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Macon, Co., Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Andrew F. Cox	13b. MOTHER'S MAIDEN NAME Suzan Lee	14. NAME OF HUSBAND OR WIFE Lyda Cox
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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. None	17. INFORMANT Address Mrs. Lyda Cox Clarence, Mo
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18. CAUSE OF DEATH (Enter only one cause per line for terminal and non-terminal)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		1 wk
IMMEDIATE CAUSE (a) UREMIA		
DUE TO (b) hypertensive cardiovascular disease		years
DUE TO (c) arteriosclerosis		years

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
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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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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
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21. I attended the deceased from **12-27-1952** to **5-2-1963** and last saw him alive on **5-2-1963**
Death occurred at **12 midnite** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Walter R. Hill M.D.	22b. ADDRESS Clarence, MO	22c. DATE SIGNED 5-8-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-5-1963	23c. NAME OF CEMETERY OR CREMATORY Maplewood	23d. LOCATION (City, town, or county) (State) Clarence, Mo.
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24. FUNERAL DIRECTOR ADDRESS Davis Funeral Service Shelbina, Mo. 5/4/63	25. DATE RECD. BY LOCAL REG. 5/4/63	26. REGISTRAR'S SIGNATURE Walter R. Hill
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VS 300
Rev. 4/59

1 **0611**
2 **1020**
3 **2**
4 **0**
5 **1**
6
7 **0**
8 **0**
9443X
10
11
12 **1-2**
13 **1-1**

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

JUN 24 1963

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 James D. Davis

Licensed Embalmer No. 4478

P. O. Address Shelbina, Mo.

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 not returned (AA)