

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED OCT 6 1944
Registration District No. 157

Primary Registration District No. 30123

Registrar's No. 145

1. PLACE OF DEATH

(a) County Henry
(b) City or town Brownington
(c) Name of hospital or institution Clinton General Hospital
(d) Length of stay: In hospital or institution 0
In this community 6 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Henry
(c) City or town Brownington
(d) Street No. _____
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Claude C. Cox

3. (b) If veteran, name war #1 3. (c) Social Security No. no

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Hera Cox 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Oct. 1 1896

8. AGE: Years 47 Months 11 Days 2 If less than one day hr. _____ min. _____

9. Birthplace Ironium Mo.

10. Usual occupation Farmer

11. Industry or business _____

12. Name Samuel Cox

13. Birthplace St. Clair Co. Mo.

14. Maiden name Regina Ashenhart

15. Birthplace Kentucky

16. (a) Informant Mrs. Hera Cox

(b) Address Brownington, Mo.

17. (a) Burial (b) Date thereof 9-5-44

(c) Place: burial or cremation Mt. Zion

18. (a) Signature of funeral director Osceola, Missouri

(b) Address Osceola, Missouri

19. (a) Sept. 8, 1944 (b) Georgia Kitchener

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 3 year 1944 hour _____ minute ✓ M.

21. I hereby certify that I attended the deceased from 8-31 1944 to 9-3 1944

that I last saw him alive on 9-3 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid Fever

Due to _____

Due to _____

Other conditions _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury ✓

23. Signature T.H. Dangler, Jr. (M. D. or other) M.D.

Address Osceola, Mo. Date signed 9-4-44

Duration

8 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

42
95

1579

3202

OCT 27 1944

RECEIVED

District Health Officer No. 7,

District File Number 9-44-1029

Date Filed 10-4-44

JAN 13 1945

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Paul J. Weston

Licensed Embalmer No. 3990

P. O. Address Oscoda 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 this body is not embalmed, fact should be so stated above.