MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5023 a

1. PLACE OF DEATH

County: Jasper — Registration District No.: 412 — File No.: 2

Township: Homestead — Primary Registration District No.: 5552 D — Registered No.:

City: (No. ..... St. ..... Ward)

2. FULL NAME: Jesse Cox

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	W	married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF ~~Lillie Cox~~

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1855

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76			

8. OCCUPATION OF DEECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Jasper Co
(STATE OR COUNTRY) Ill

PARENTS

10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

14. INFORMANT P. L. Cox
(Address) Springfield Mo

15. FILED 8/8 1926 W. F. Hogan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 8th 1926

17. I HEREBY CERTIFY, That I attended deceased from March, 1925, to Feb 8, 1926, that I last saw h. alive on Feb 8, 1926, and that death occurred, on the date stated above, at 8 A. m.

18a. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis & Chronic Nephritis
Infirmity of Bronchial tubes
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Influenza & Pneumonia
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF?
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. F. Hogan, M. D.
8/8, 1926 (Address) W. F. Hogan

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Galena Ks	8/9 1926
20. UNDERTAKER	**ADDRESS**
Claxton Co	Galena Ks

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms; so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ... St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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