

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

Do not use this space.

2374-a

2374 a

PLACE OF DEATH

County Franklin
Township Franklin
City Franklin (No.)

Registration District No. 205-2
Primary Registration District No.

File No. 4
Registered No.
St. Ward)

2. FULL NAME Lewis G. Ligan 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Elizabeth Cox
6. DATE OF BIRTH (MONTH AND YEAR) 1830
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 | 1 | 19

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(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) Carolina

10. NAME OF FATHER Joseph Cox
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Carolina
12. MAIDEN NAME OF MOTHER Ann Reynolds
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) North

14. INFORMANT My Roy Fender
(Address) Frankfort, Mo

15. FILE 1-16-29 C.M. Coy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-15-29
17. I HEREBY CERTIFY, That I attended deceased from 1-1-29 to 1-15-29, 1929, that I last saw him alive on 1-12-29, 1929, and that death occurred, on the date stated above, at 8 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
92A
107 B (duration) yrs. mos. ds. 26
CONTRIBUTORY Tubular Infection (SECONDARY) (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH, Home
DID AN OPERATION PRECEDE DEATH? no DATE OF -
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) G. J. Harris, M. D.
19 (Address) Frankfort Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Airy DATE OF BURIAL 1-18-29

20. UNDERTAKER H. H. Robertson ADDRESS Frankfort Mo

STATE OF MISSOURI, DEPARTMENT OF HEALTH, BUREAU OF VITAL STATISTICS, FRANKFORD, MISSOURI

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Livingston Registration District No. 962 File No. 9
Township Jackson Primary Registration District No. 3678 Registered No. _____
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Lewis Elijah 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mrs Elizabeth Cox</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec 10 - 1830</u>		
7. AGE	YEARS <u>78</u>	MONTHS <u>1</u>
	DAYS <u>28</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Retired</u> (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) <u>Carolina</u>		
PARENTS	10. NAME OF FATHER <u>Joseph</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Carolina</u>	
	12. MAIDEN NAME OF MOTHER <u>Wm. Reynolds</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>don't know</u>	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10 1929

17. I HEREBY CERTIFY that I attended deceased from 1-1-1929 to 1-13-1929 that I last saw him alive on 1-2-1929 and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial pneumonia

CONTRIBUTORY (SECONDARY) Valvular Insufficiency (duration) 2 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Home
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) G. D. Harris, M. D.

*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.

14. INFORMANT Wm. Fendler
(Address) Jmesport Mo

15. FILED 8-5-1929 N. S. White
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Arie DATE OF BURIAL 1-18 1929

20. UNDERTAKER H. B. Roberson ADDRESS Jmesport Mo

N. S. White, Registrar, should be stated EXACTLY. PHYSICIANS should state EXACTLY. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SMALL. ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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