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.

REC'D OCT 15 1938

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

Do not use this space.

31441

1. PLACE OF DEATH
County Jackson
Township Kaw
City K.C.Mo. (No. St. Lukes Hospital St. Ward)

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 3738

2. FULL NAME May J.Heil Cox
(a) Residence, No. 300 West 34th. St 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 Fem
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 Freeman O. Cox

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unk 1884

7. AGE YEARS 54 MONTHS DAYS If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennslyvania

FATHER
13. NAME Solomon Schreffler
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

MOTHER
15. MAIDEN NAME Margaret Rowe
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

17. INFORMANT (ADDRESS) Freeman O. Cox 300 West 34th St. K.C.Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Wichita, Kans. DATE 9/26/38 19

19. UNDERTAKER (ADDRESS) J.F.O'Donnell, Co. 3256 Broadway

20. FILED Sept 26, 1938 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 26, 1938

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., 19....
I last saw h... alive on ..... 19.... Death is said to have occurred on the date stated above, at 12 a m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Massive Cerebral Hemorrhage	50 or 6 Hrs
8 a m	

Other contributory causes of importance:

Malignant Hypertension	yrs

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) [signature], M. D.
(Address) St. Lukes Hospital K.C. Mo