

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.

JAN 31 1940

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

42781  
 Do not use this space.

1. PLACE OF DEATH  
 (a) County Buchanan Registration District No. 85  
 (b) Township St Joseph Primary Registration District No. 1001 Registered No. 1256  
 (c) City St Joseph (d) Street No. Mo. Meth Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME FRED JACKSON COX  
 (a) Residence, No. Halls Mo. RR #1 St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**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 JESSIE COX  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 30th 1884  
 7. AGE YEARS 55 MONTHS 8 DAYS 3 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Merchantile Bus.  
 9. Industry or business in which work was done, as 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) CRESTON Iowa  
 13. NAME John Cox  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) EAST TENN.  
 15. MAIDEN NAME DRUCELLA TOWNSEND  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wolff County Kentucky  
 17. INFORMANT (ADDRESS) Mrs. F. J. Cox RR #1 Halls, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE Dec. 6th 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Freeman & Son 1946 Calhoun St. Joseph, Mo  
 20. FILED 12/5 1939 W. Woodhull Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) DEC. 3rd 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Dec 7 1939 to Dec 3 1939  
 I last saw him alive on Dec 3 1939 Death is said to have occurred on the date stated above, at 11:15 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Embolism cerebral Date of onset Dec 1-39  
59  
 Other contributory causes of importance:  
Heart disease and vessel decompensated  
Arterio Sclerosis Nephritis  
 Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? clinical Was there an autopsy? no  
 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? no  
 If so, specify \_\_\_\_\_  
 (Signed) F. J. Cox, M. D.  
85 (Address) St. Joseph, Mo.

**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 C. G. Swan

Licensed Embalmer No. 4082

P. O. Address St. Joseph

**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, above space should be left blank.**