ED APR 23 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12676

Registration District No. 866 Primary Registration District No. 6146 Registrar's No.

1. PLACE OF DEATH:

(a) County ~~Shannon~~ Texas

(b) ~~City or town~~ Current Twp. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution xxxx (Specify whether In this community all her life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas

(c) City or town Current Rural (If outside city or town limits, write "RURAL")

(d) Street No. xx XX (If rural, give location)

(e) If foreign born, how long in U. S. A.? xx years.

3. (a) PRINT FULL NAME Chrystel Cox 200

3. (b) If veteran, name war xxx

3. (c) Social Security No. xx

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife xx

6. (c) Age of husband or wife if alive X years

7. Birth date of deceased June (Month) 16 (Day) 1925 (Year)

8. AGE: Years 14 Months 8 Days 21 If less than one day ..... hr. ..... min.

9. Birthplace Shannon Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation schoolgirl

11. Industry or business xxx

FATHER
12. Name Isaac F Cox
13. Birthplace Shannon Co (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Della Howell
15. Birthplace Shannon Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant's own signature I F Cox

(b) Address Cedar Grove Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 3/9/40 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ Jadwin Mo

18. (a) Signature of funeral director XXXXX 785

(b) Address Jadwin Mo

19. (a) March 15-1940 (Date received local registrar) Maggie E Murphy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 7 year 1940 hour 10 minute X A M.

21. I hereby certify that I attended the deceased from Feb 10, 1940, to Mar 7, 1940; that I last saw her alive on Mar 6, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Typhoid

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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? (City or town) (County) (State)

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

While at work? (e) Means of injury

23. Signature Lisbeth Lindsey (M. D. or other) MD

Address Liberty Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.

1 X19511

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.

RECEIVED

District Health Officer No. 5,

District File Number 440413

Date Filed 4/1/40

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.