

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
STANDARD CERTIFICATE OF DEATH

14149

State File No. _____

Registration District No. 11

Primary Registration District No. 5014

Registrar's No. 31

1. PLACE OF DEATH:
(a) County ANDREW
(b) City or town SAVANNAH CLAY TOWNSHIP RURAL #4
(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 _____ (Specify whether)
In this community 40 years
years, months or days

3. (a) PRINT FULL NAME GEORGE COX 2nd
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased OCT 31 1861
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

10. Usual occupation CARPENTER

11. Industry or business _____

MOTHER FATHER
12. Name UNKNOWN 9
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN 9
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Clay E. Hutchman
(b) Address Savannah Mo
17. (a) _____ (b) Date thereof 4-13-1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation SAVANNAH

18. (a) Signature of funeral director Phisal Ashburn
(b) Address Savannah Mo
19. (a) Apr. 12-40 (b) Mrs. Addie Barnes
(Date received local registrar) (Registrar's signature) Rash

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Andrew
(c) City or town Savannah Mo Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) _____
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11
year 1940 hour 3:30 minute _____ M.
21. I hereby certify that I attended the deceased from The Body
_____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Exposure from cold Duration ?

Due to _____
Due to _____

Other conditions 190
(include pregnancy within 3 months of death) 4

Major findings:
Of operations _____
Of autopsy _____
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) Accident
(b) Date of occurrence April 11 1940
(c) Where did injury occur Andrew Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On Farm

While at work? No (Specify type of place) (e) Means of injury _____

23. Signature C. L. Stidley 3 (M. D. or other) do
Address Savannah Mo Date signed 4/14/40

RECEIVED
District Health Officer No. 11,
District File Number 540-641
Date Filed MAY 6 1940

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.....

J. Fred Turham....., Registered Apprentice No. 1279
working under my personal supervision.

Signed J. Fred Turham
Licensed Embalmer No. 1279
P. O. Address Savannah

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.