

JUN 16 1946 486  
Registration District No.

Primary Registration District No. 4299

Registrar's No. 12

## 1. PLACE OF DEATH:

- (a) County Lincoln  
 (b) City or town Estling  
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution
- 2
- 
- (Specify whether

In this community 2  
years, months or days)8. (a) PRINT FULL NAME W. T. Cox 2011

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced Widow6. (b) Name of husband or wife W. T. Cox 6. (c) Age of husband or wife if7. Birth date of deceased May 25 1856  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
83 11 7 hr. min.9. Birthplace Lincoln Co Mo (City, town, or county) (State or foreign country)10. Usual occupation Retired Farmer11. Industry or business Retired Farmer12. Name Hampson Cox18. Birthplace W. A. (City, town, or county) (State or foreign country)14. Maiden name Best (City, town, or county) (State or foreign country)15. Birthplace W. A. (City, town, or county) (State or foreign country)16. (a) Informant's own signature Fred Cox(b) Address Estling Mo17. (a) Burial (b) Date thereof May 5-40  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Estling Cemetery18. (a) Signature of funeral director W. H. Bradley(b) Address Estling Mo19. (a) June 10-46 (b) E. H. Howell  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lincoln(c) City or town Estling  
(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 May day 2-8  
year 1940 hour 5 15 minute P M.21. I hereby certify that I attended the deceased from Jan 30  
1940, to May 2nd 1940  
that I last saw him alive on May 2nd 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary Thrombosis 5 days  
Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)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) \_\_\_\_\_

(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?  
YesWhile at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_23. Signature W. C. Hatcher (M. D. or other) MD  
Address Estling, Mo. Date signed 5/14/40

**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 W H Bradley

Licensed Embalmer No. 3966

P. O. Address Fl. Hwy

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 18886

Registration District No. 486

Primary Registration District No. 4793

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) City or town Lincoln  
(b) City or town Elaberry  
(If outside city or town limits, write "RURAL" and name of township)  
Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME

Wm. Thomas Vall Roy

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 wid

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 83 Months 11 Days 7  
If less than one year, hr. min.

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

MOTHER FATHER

11. Industry or business  
12. Name \_\_\_\_\_  
13. Birthplace (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 7-10-40 (b) Etta Powell  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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 May day 2  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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?  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Means of injury)  
23. Signature H.C. Hatcher (M. D. or other) \_\_\_\_\_  
Address Elaberry, Mo Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY COPY

S-18886