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1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2753

Registration District No. 657

Primary Registration District No. 4388

Registrar's No. 93

1. PLACE OF DEATH:

(a) County Pennick

(b) City or town Cauthersville
(If outside city or town limits, write "RURAL" and name of township)

(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 yrs.
years, months or days

3. (a) PRINT FULL NAME Joanna Addie Cox

3. (b) If veteran, name war None

3. (c) Social Security No None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive 20 years (Day) (Year)

7. Birth date of deceased 2 (Month) 20 (Day) 1869 (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>7</u>	<u>3</u>	hr. min.

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

10. Usual occupation Housework 9

11. Industry or business 9

12. Name John Belton 9

13. Birthplace D.K. (City, town, or county) (State or foreign country)

14. Maiden name D.K.

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

16. (a) Informant Mrs. Ruth Wagner

(b) Address Cauthersville Mo.

17. (a) Burial (b) Date thereof 9-24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Cemetery

18. (a) Signature of funeral director W. S. Smith

(b) Address Cauthersville Mo.

19. (a) Sept. 26, 1940 (b) Ada Martin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pennick

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

(d) Street No. Laramie Ave
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 23
year 40 hour 2 minute 30 P M.

21. I hereby certify that I attended the deceased from Sept. 23, 1940 to Sept. 23, 1940
that I last saw her alive on Sept. 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Organic heart disease

Due to undetermined

Other conditions (Include pregnancy within 3 months of death) None

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? _____

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While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature J. W. Chappel (M. D. or other) 12/1/40
Address Cauthersville Mo. Date signed _____

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

MOTHER FATHER

10-40-20

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

Noel C. Dean

Licensed Embalmer No. *3941*

P. O. Address

Cynthiansville

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, fact should be so stated above.