

No. 2
11-10-39
5-17-39
I X21432

JAN 25 1941
Registration District No. 250

Primary Registration District No. 4150

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Daviess
(b) City or town Gallatin
(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 life
In this community life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County DAVIESS
(c) City or town GALLATIN MO.
(d) Street No. 0
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME Lydia Hane Cox

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex fe. 5. Color White 6. (a) Single, widowed, divorced, married
6. (b) Name of husband or wife A.J. COX 6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased June 27 1869
(Month) (Day) (Year)

8. AGE: Years 71 Months 5 Days 9 If less than one day hr. _____ min. _____

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

10. Usual occupation housewife

11. Industry or business _____

12. Name Geo. Curtiss
13. Birthplace Missouri
14. Maiden name Sarah Nickerson
15. Birthplace Missouri

16. (a) Informant A.J. Cox
(b) Address Gallatin Mo.

17. (a) burial (b) Date thereof Dec. 8, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McCrary Cem

18. (a) Signature of funeral director E. M. Gorman

(b) Address Gallatin Mo.

19. (a) 12-7-40 (b) H. G. Hope
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 6
year 1940 hour 3 1/2 minute 40 A.M.

21. I hereby certify that I attended the deceased from June 20
1940, to Dec 20, 1940

that I last saw her alive on Nov 20, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to Reproduction - cardiac vascular renal disease

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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? _____

(e) Means of injury _____

23. Signature M. P. Paulson M.D. or other _____

Address Gallatin Mo. Date signed 12/7/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

1
2
0

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 *E. M. Jordan*

Licensed Embalmer No. 3453

P. O. Address Salisbury Mo

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.