

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.

JAN 20 1941 508
Registration District No. 508

Primary Registration District No. 3026

State File No. _____

Registrar's No. 159

1. PLACE OF DEATH:

(a) County Linnington

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

(c) Name of hospital or institution: 1126 Park St.
(If not in hospital or institution, write street number or location)

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

In this community 15 years.
years, months or days (Specify whether 20)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linnington

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

(d) Street No. 1126 Park St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Pearl M. Cox

3. (b) If veteran, name war _____

3. (c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 13
year 1940 hour 7 minute 50 P.M.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Daniel E. Cox

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Nov. 26 1891
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 1-40, 1940, to 12-12, 1940, that I last saw her alive on 12-10-, 1940; and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>0</u>	<u>16</u>	hr. _____ min. _____

Immediate cause of death Pulmonary Tuberculosis

Due to _____

Due to _____

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

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

10. Usual occupation At Home

Major findings:
Of operations ✓

Of autopsy ✓

PHYSICIAN _____

Underline the cause to which death should be charged statistically

MOTHER FATHER

12. Name Grant Safferty

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

14. Maiden name Maunse G. W. W.

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

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? 043

16. (a) Informant's own signature Daniel E. Cox

(b) Address Chillicothe, Mo.

17. (a) Burial (b) Date thereof Dec. 14, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Chillicothe, Mo.

18. (a) Signature of funeral director Ronald F. Jordan

(b) Address Chillicothe, Mo.

19. (a) 12-14-40 (b) H. W. Bruce, M.D.
(Date received local registrar) (Registrar's signature)

(Specify type of place) _____

(Specify means of injury) _____

23. Signature Reuben Roney (M. D. or other) _____

Address Chillicothe Mo. Date signed 12/23/40

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 Ronald J. Gardner
Licensed Embalmer No. 4191
P. O. Address Chillicothe, 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.