

No. 2
1-4-41
1-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20705

State File No. _____

FILED SEP 11 1941

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2235

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K.C. Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
D. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 1 year years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1836 Newburn
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CLARENCE COX

3. (b) If veteran, name war World war 3. (c) Social Security No. 499-14-1918

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife ORA 6. (c) Age of husband or wife if alive 34 years
7. Birth date of deceased Mar 6 1897
(Month) (Day) (Year)

8. AGE: Years 44 Months 3 Days 3 If less than one day hr. min.

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

10. Usual occupation Cook

11. Industry or business _____

12. Name Simon P. Cox

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

14. Maiden name Mary Anderson

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

16. (a) Informant Simon P. Cox

(b) Address 1627 Griffing

17. (a) Burial (b) Date thereof 6/10/41
(Burial, cremation, or removal) (Month) (Year)

(c) Place: burial or cremation Green Lawn C.

18. (a) Signature of funeral director Snow Mayling

(b) Address 2315 Linwood

19. (a) 6/11/1941 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day 6-9-41 year _____ hour _____ minute 15 P. M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that he/she was _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Subdural & subarachnoid cerebral hemorrhage
fracture of the skull
Extensive peri vascular pelvic hemorrhage
fracture of the pelvis
Auto mobile trauma

Duration

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy Yes

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 6-9-41

(c) Where did injury occur U.S. Highway #71 - Harrisonville Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, or in public place
Pedestrian struck by auto
(Specify type of place) (Specify place of injury)

While at work? _____

23. Signature Walter W. Miller (M. D. or other)

Address 14-C-200 Date signed _____

361 (Licensed Embalmer's Statement on Reverse Side)

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

048
3
8

JUL 12 1941

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.....

Ray E. Snow

Licensed Embalmer No. *2560*

P. O. Address... *1807 East 29th*

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.