S. No. 2
M—1-4-41
v. 5-17-39
I X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 14 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24965

Registration District No. 253

Primary Registration District No. ~~5308~~ 8351B

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Daviess
(b) City or town "Rural" Jackson Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7 Miles East Gallatin, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 5 Months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Daviess
(c) City or town "Rural" Jackson Township
(If outside city or town limits, write "RURAL")
(d) Street No. 7 Miles East Gallatin, Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John William Cox
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nancy Kathryn Cox
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased May (Month) 20 (Day) 1871 (Year)
8. AGE: Years 70 Months 1 Days 16 If less than one day ____ hr. ____ min.
9. Birthplace Carroll County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Fred Cox
13. Birthplace Unknown (City, town, or county) Missouri (State or foreign country)
MOTHER 14. Maiden name Mollie Murphy
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Ross Cox
(b) Address Gallatin, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Centenary Cemetery
18. (a) Signature of funeral director
(b) Address Gallatin, Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6 year 1941 hour 7 minute 30 A. M.
21. I hereby certify that I attended the deceased from ____ 19__ to ____ 19__; that I last saw him alive on July 6 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis — 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature C. B. Bailey (Coroner) (M. D. or other) D.O.
Address Jamesport, Mo. Date signed 7-17-41

(Licensed Embalmer's Statement on Reverse Side)

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.....L. O. Pickerson.....

Licensed Embalmer No.....3302.....

P. O. Address.....Gallatin, Tn.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

V. S. No. 2B
20M—8-21-41
1 X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24965

Registration District No. 253 Primary Registration District No. 5353 Registrar's No.

1. PLACE OF DEATH:

(a) County Daviess

(b) City or town Jackson Twp. (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 (Specify whether years, months or days)

In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John W. Cox

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 M

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 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) July 20, 1941 (Date received local registrar) (b) A. G. Minnich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 6 year 1941 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	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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature G. E. Minnich (M. D. or other)

Address Lost Springs Date signed 9/44

SUPPLEMENTARY

S-24965