

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 9 1943
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 227

Registration District No. 274 Primary Registration District No. 3052

1. PLACE OF DEATH:
(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
420 E 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 45 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Pettis
(c) City or town Sedalia
(If outside city or town limits, write "RURAL")
(d) Street No. 420 E 4
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Joe Cox

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Lucy Cox 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 27 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 11 17 _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business Machinist

12. Name John Cox

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

14. Maiden name Mary O. Fallon

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

16. (a) Informant Mrs. John Cox

(b) Address Sedalia Mo.

17. (a) burial (b) Date thereof July 16 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director McLaughlin Bros.

(b) Address Sedalia Mo.

19. (a) 7/15/43 (b) Anna Berger
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 14 1943
year hour 2 A minute _____ M.

21. I hereby certify that I attended the deceased from over 12 years 19 _____ to July 14 1943
that I last saw him alive on July 13 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration 2 years

Due to Chronic Nephritis 29 years

Due to Aneurysm 29 years

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

Major findings: Of operations none

Of autopsy no

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

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

23. Signature Dr. B. Quilley M.D. (M. D. or other) _____

Address Sedalia Mo Date signed 7-15-43

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

80
6
4

80
6
4

0

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

11222

RECEIVED

District Health Officer No: 8

District File Number

Date Filed 8-6-43

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

Robert H. Reed

Licensed Embalmer No.

3745

P. O. Address

Sedalia 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, fact should be so stated above.