

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 17 1943

268

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42492

Registration District No. 176

Primary Registration District No. 5568

Registrar's No. 290

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
570 - ARLINGTON
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 2 MONTHS years, months or days)

3. (a) PRINT FULL NAME MRS. ADA LEONA COX

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, 2 divorced WIDOWED

6. (b) Name of husband or wife MR. JAMES R. COX 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased SEPTEMBER 2 - 1873
(Month) (Day) (Year)

8. AGE: Years 78 Months 2 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation AT HOME

11. Industry or business _____

12. Name HENRY SNOW

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

14. Maiden name MARY MUELLER

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

16. (a) Informant MRS. R. J. POWELL

(b) Address 570 ARLINGTON

17. (a) BURIAL (b) Date thereof NOV 15 1943
(Burial, cremation, or removal) (City or town) (County) (State)

(c) Place: burial or cremation 7 MILES N. BUFFALO, MISSOURI

18. (a) Signature of funeral director W. H. Williams, Sons

(b) Address KANSAS CITY, MISSOURI

19. (a) 11-15-43 (b) J. Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DALLAS³⁰
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. BUFFALO
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 15TH
year 1943 hour 3 minute 15 A.M.

21. I hereby certify that I attended the deceased from Oct 6, 1943 to Nov 15, 1943
that I last saw her alive on Nov 14, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial pneumonia Duration 3 days

Due to impoverished condition

Due to Pulmonary tuberculosis 18 mos.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____
PHYSICIAN 1281
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? _____

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

23. Signature J. W. Hill M.D. (M.D. or other) 11/15/43
Address 438 1/2 Adams Ave Independence Mo. Date signed _____

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

MOTHER, FATHER

JUL 6 1948

1458
Newcomer

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 *R. C. Newcomer*

Licensed Embalmer No. *7045*

P. O. Address *R. C. 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.

Registration District No. 146

Primary Registration District No. 5568

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Inter City Dist. Blue 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
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Ada Leona Cox

3. (b) If veteran, name war

3. (c) Social Security No. _____

4. Sex F

5. Color of race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 2
(Month) (Day) (Year)

8. AGE: Years 20 Months 2 Days 13 (Unless than one day) min.

9. Birthplace (City, town, or county) Ind.

(State or foreign country)

10. Usual occupation

11. Industry or business

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 12-31-43
(Date received local registrar)

(b) Jamer W. Rose
(Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 2 Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

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

Address _____ Date signed _____

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

SUPPLEMENTARY

S-42492