. No. 2
—9-4-41
5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 17 1943

Registration District No. 209

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3043

State File No. 42931

Registrar's No. 316

1. PLACE OF DEATH:

(a) County MARION

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

(c) Name of hospital or institution: ST. ELIZABETH
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community LIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County PIKE 82

(c) City or town FRANKFORD 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? no - (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME CHARLEY COX

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex MALE

5. Color or race 2 NEGRO

6. (a) Single, widowed, married, divorced 2 WIDOWED

6. (b) Name of husband or wife MARGARET COX

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

7. Birth date of deceased JULY (Month) 9 (Day) 1864 (Year)

8. AGE: Years 79 Months 3 Days 8 If less than one day ___ hr. ___ min.

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

10. Usual occupation FARMER RETIRED

11. Industry or business -

FATHER
12. Name SAM COX
13. Birthplace VIRGINIA (City, town, or county) / (State or foreign country)

MOTHER
14. Maiden name CAROLINA
15. Birthplace VIRGINIA (City, town, or county) / (State or foreign country)

16. (a) Informant Mrs. Minnie Braxton
(b) Address Fulton, Mo.

17. (a) Oct. 19-43 (Burial, cremation, or [illegible]) FRANKFORD (b) Date thereof Oct 13-43 (Month) (Day) (Year)
(c) Place: burial or cremation FRANKFORD Mo.

18. (a) Signature of funeral director Fields & Son
(b) Address Frankford, Mo -

19. (a) 10/21/43 (Date received local registrar) (b) R W Connor (Registrar's signature)

1146

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18 year 43 hour 12 30 minute a M.

21. I hereby certify that I attended the deceased from Oct 11-43, 19__, to Oct 18-43, 19__ that I last saw him alive on Oct 18-43, 19__ and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis & Uremia

Due to

Due to Enlarged Prostate with possibly Cancer.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 51 b

Of autopsy

Duration

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 H B M Mecker (M. D. or other) M.D.

Address Hannibal Mo Date signed 10/18/43

(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 Lone Fields Megown

Licensed Embalmer No. 4092

P. O. Address Frankford, 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.