S. No. 2
M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 15 1945

Registration District No. 8 1845

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3006

State File No. 12782

Registrar's No. 86

1. PLACE OF DEATH:

(a) County BOONE

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

(c) Name of hospital or institution: ELLIS FISCHEL STATE CANCER HOSP (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 52 DAYS (Specify whether years, months or days)

In this community YES.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLINTON

(c) City or town PLATTSBURG 25 (If outside city or town limits, write "RURAL")

(d) Street No. 3 (If rural, give location)

(e) Citizen of foreign country? 1 (~~Yes or~~ No)

If yes, name country 1

3. (a) PRINT FULL NAME John MARSHALL COZART

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~~ 1

6. (b) Name of husband or wife Ruby COZART

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

7. Birth date of deceased July (Month) 30 (Day) 1889 (Year)

8. AGE: Years 55 Months 8 Days 2 If less than one day — hr. min.

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

10. Usual occupation VETERINARIAN

11. Industry or business

FATHER
12. Name M.H. COZART
13. Birthplace NEW ORLEANS (City, town, or county) LA. (State or foreign country)

MOTHER
14. Maiden name HELEN HOOPER
15. Birthplace TIPSON (City, town, or county) TEXAS (State or foreign country)

16. (a) Informant Pt. (John COZART)

(b) Address PLATTSBURG MO.

17. (a) Burial & Removal (Burial, cremation, or removal) (b) Date thereof 4-4-45 (Month) (Day) (Year)

(c) Place: burial or cremation Plattsburg, MO

18. (a) Signature of funeral director Lyon Funeral Home

(b) Address Stewartville, MO

19. (a) 4-2-45 (Date received local registrar) (b) Edna H. Barber (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 2 year 1945 hour 1 minute 05 A.M.

21. I hereby certify that I attended the deceased from 2-9, 1945 to 4-2, 1945; that I last saw him alive on 4-2, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardiac Decompensation following Portal obstruction	1 day
~~Due to~~ perhaps due to metastases from Rt mediastinal tumor	7 mo.
~~Due to~~ which the patient had, compressing the portal vein.	

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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 R. J. Westcott (M. D. or other) MD

Address State Cancer Hosp. Columbia, Mo. Date signed 4-2-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 5-14-45

MAR 17 1954

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 I G Lyon

Licensed Embalmer No. 952

P. O. Address Stewartsville, 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.