

FILED JUN 14 1945

State File No. _____

Registration District No. 98

Primary Registration District No. 5367

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Daviess
(b) City or town Wheatland Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Monroe Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 7 3/4 yrs
years, months or days

3. (a) PRINT FULL NAME Albert E. Cox
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Mable Sampson Cox 6. (c) Age of husband or wife if alive 72 (72) years
7. Birth date of deceased 7/10/1871
(Month) (Day) (Year)

8. AGE: Years 73 Months 4 Days 19 If less than one day
hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER
12. Name Benjamin F Cox
13. Birthplace Daviess Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name Lee Ann Leckford
15. Birthplace James Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Sarah Cox
(b) Address Hamilton Mo

17. (a) Burial (b) Date thereof Mar 25-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Cem Hamilton Mo

18. (a) Signature of funeral director Frank Saut
(b) Address Hamilton Mo

19. (a) 5-12-1945 (b) A. O. Fishman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Daviess
(c) City or town Monroe Twp Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23
year 1945 hour 1 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan
9 1945 to Feb 20 1945
that I last saw him alive on Feb 20 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic degeneration of the heart muscle Duration 2 yrs

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: E. A. Thompson MD Of operations _____

Of autopsy no 93d 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? _____

(e) While at work? no (Specify type of place) (f) Means of injury _____

23. Signature E. A. Thompson (M. D. or other) _____

Address Greenridge Mo Date signed _____

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

100

RECEIVED
District Health Officer No. 11,
District File Number
Date Filed

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 Morris A. Brown
Licensed Embalmer No. 3918
P. O. Address Hamilton, 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.