DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41541

FILED JAN 11 1946

Registration District No. 2 Primary Registration District No. 3031 Registrar's No. 70

1. PLACE OF DEATH:

(a) County: Jefferson

(b) City or town: De Soto Mo

(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 years, months or days)

In this community: 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Jefferson 50

(c) City or town: De Soto 2

(If outside city or town limits, write "RURAL")

(d) Street No.: Commercial Hotel 2

(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: CLAY BOURNE PRICE COX

3. (b) If veteran, name war: —

3. (c) Social Security No.: —

4. Sex: M

5. Color or race: W

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

6. (b) Name of husband or wife: Kate Cox

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

7. Birth date of deceased: 9/27/1863 (Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 3 If less than one day ..... hr. ..... min.

9. Birthplace: New Hope (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Retired Farmer

11. Industry or business: [illegible]

MOTHER FATHER

12. Name: [illegible]

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

14. Maiden name: Caroline M. Edwards

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

16. (a) Informant: Mrs. Wm Gillam

(b) Address: Ironton Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 2 1946 (Month) (Day) (Year)

(c) Place: burial or cremation: Crystal Mo.

18. (a) Signature of funeral director: [illegible] White

(b) Address: Ironton Mo.

19. (a) 1/2/46 (Date received local registrar) (b) Marie Harris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 30 year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from 12/28 1945 to 12/30 1945 that I last saw alive on 12/30 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Gall Stones

Due to:

Due to:

Other conditions: Senility

(Include pregnancy within 3 months of death)

Major findings:
Of operations: 126

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: Chas E Zellet (M. D. or other)

Address: De Soto Mo Date signed: 1/8/45

1645 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 1-10-46

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 G B Dietrich
Licensed Embalmer No. 4104
P. O. Address Dedato 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.