

No. 2
-12-45
-17-39
X47070

FILED JAN 27 1947

Registration District No. **277**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **JACKSON**
(b) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
317 EAST 69TH TERRACE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
in this community **20 YEARS** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON**
(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
(d) Street No. **317 EAST 69TH TERRACE**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MR ORRIN DENT COX**

3. (b) If veteran, name war **WORLD WAR I** 3. (c) Social Security No. **361-10-7878**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **MRS. FERN H. COX** 6. (c) Age of husband or wife if alive **50** years
7. Birth date of deceased **JUNE 21 1895**
(Month) (Day) (Year)

8. AGE: Years **51** Months **6** Days **26** If less than one day hr. min.

9. Birthplace **REMP ILLINOIS**
(City, town, or county) (State or foreign country)

10. Usual occupation **STATE AGENT**

11. Industry or business **AMERICAN INSURANCE GROUP**

12. Name **J. MONROE COX**

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

14. Maiden name **MILA HUGHES**

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

16. (a) Informant **MRS. FERN H. COX**

(b) Address **317 EAST 69TH TERRACE**

17. (a) **REMOVAL** (b) Date thereof **1-18-47**
(Burial, cremation, or removal) (City or town) (County) (State)

(c) Place: burial or cremation **GRANDVIEW CEMETERY PARIS, ILLINOIS**

18. (a) Signature of funeral director **D.H. Newberry, Jr.**

(b) Address **1401 BROS CREEK BLYD.**

19. (a) **1-18-47** (b) **Geraldine Holme**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JANUARY**, day **17**TH, year **1947**, hour **3**, minute **30 A.**, M.

21. I hereby certify that I attended the deceased from **12-17 1945**, to **1-17 1947**, that I last saw him alive on **1-10 1947**, and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Arteriosclerosis**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **940**

Of autopsy _____

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 **Freel Perry** (M. D. or other) **H.D.**

Address **1610 Professional Bldg.** Date signed **1-17-47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Emile M. Calloway

Licensed Embalmer No. 3506

P. O. Address Kc 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.