S. No. 2
M—5-43
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I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 5 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1036

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 356

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 512 Woodland 4 cow. Home (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs (Specify whether

In this community " " years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 44

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3

(d) Street No. 512 Woodland (If rural, give location) 8

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

If yes, name country

3. (a) PRINT FULL NAME Sarah Jane Cox

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex female

5. Color or race Wht

6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased 2 (Month) - 8 (Day) - 1855 (Year)

8. AGE: Years 91 Months 11 Days 16 If less than one day hr. min.

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

10. Usual occupation None

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) unknown (State or foreign country) 9

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country) 9

16. (a) Informant Ann Clark

(b) Address 519 Bales

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1 (Month) / 24 (Day) / 47 (Year)

(c) Place: burial or cremation Warrensburg Mo

18. (a) Signature of funeral director Stine McClure

(b) Address Kansas City Mo

19. (a) 1-25-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24 year 1947 hour 4 minute 30 P M.

21. I hereby certify that I attended the deceased from 1-20-47, 19, to 1-24, 1947 that I last saw her alive on 1-24, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar pneumonia	
Due to: arteriosclerosis	
Due to: Chronic myocarditis	
Other conditions: (Include pregnancy within 3 months of death)	

Major findings:
Of operations 108
Of autopsy

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 1-24-47

(c) Where did injury occur? K C Jackson Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)

While at work? (e) Means of injury 0

23. Signature D M Wigro (M. D. or other) M D

Address 925 Argyle Bldg Date signed 1-25-47

(Licensed Embalmer's Statement on Reverse Side)

Ver N.1 Gro
Apple Bldg
Ha. 2 3 88

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 Robert H Reed

Licensed Embalmer No. 3745

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.