

S. No. 2  
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17-39  
K26390

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED APR 9 1948

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

11226

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 6149

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Stoddard  
(b) City or town Puxico Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 6 years (Specify whether  
in this community. 6 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard  
(c) City or town Puxico 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 \_\_\_\_\_

3. (a) PRINT Sarah Elizabeth Cox  
FULL NAME

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife James Cox 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 30 1969  
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 2 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation not employed

11. Industry or business \_\_\_\_\_

12. Name William G. Brown  
13. Birthplace Ridgeway Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Annella Dillard  
(City, town, or county) (State or foreign country)

15. Birthplace Don't Know  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bettie Kirk  
(b) Address Puxico, Mo. R. 2

17. (a) Burial (b) Date thereof March 4 48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place, burial or cremation Puxico Cemetery

18. (a) Signature of funeral director Watkins Fun. Ser. Inc  
(b) Address Puxico, Mo.

19. (a) Mar. 5 1948 (b) Playd Morgan  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

March 2nd

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
year 1948 hour 1.00 a.m. Minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from Jan 1947 to Mar 2 1948  
that I last saw her alive on Feb 24 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure Duration \_\_\_\_\_

Due to nephritis

Due to arterio sclerosis

Other conditions hypertension  
(Includes pregnancy within 7 months of death)

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_  
ADDITIONAL PHYSICIAN SUPPLEMENTARY INFORMATION 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. H. Skilling (M. D. or other) DO  
Address Puxico Date signed 3/2/48

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 448 - 464

Date Filed 4-8-48

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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 Lynn A. Steele

Licensed Embalmer No. 2476

P. O. Address Weymouth, Mass.

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. April  
Registrar's No. 2Registration District No. 339Primary Registration District No. 6149

## 1. PLACE OF DEATH:

(a) County Stoddard Rural  
 (b) City or town Rural  
 (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 \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days)

## 3. (a) PRINT FULL NAME

Larrah E. Cox3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex F 5. Color or race W6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

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

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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

SUPPLEMENTARY

S-11226

with ...  
and  
P ...