FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 26 1948

Registration District No. 1753

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5430

State File No. 22753

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Rural

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Central Wp-1

(If not in hospital or institution, write street number or location)

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

In this community 2 days - 12 hrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Franklin

(c) City or town Rural

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

(d) Street No. St. Clair - R.R. #2

(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Sandra May Cox

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July - 2 - 1948 (Month) (Day) (Year)

8. AGE: Years | Months | Days 2 | If less than one day 12 hr. min.

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

10. Usual occupation

11. Industry or business

FATHER

12. Name Roy Ware Cox

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

MOTHER

14. Maiden name Dollie Brunett

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

16. (a) Informant Dollie Cox

(b) Address St. Clair - MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-48 (Month) (Day) (Year)

(c) Place: burial or cremation Mt Zion

18. (a) Signature of funeral director Sherwood Kitchell

(b) Address St. Clair MO

19. (a) 7-5-1948 (Date received local registrar) (b) Paul E. Miller Deputy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5 year 1948 hour 10 minute a M.

21. I hereby certify that I attended the deceased from 7-2-1948 to 7-6-1948 that I last saw her alive on 7-6-1948 and that death occurred on the date and hour stated above.

Immediate cause of death

Intussusception

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

157

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 W. E. Kitchell (M. D. or other) M.D.

Address St. Clair Date signed 7/8

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUL 23 1948

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. Sherwood Mitchell

Licensed Embalmer No. 3873.

P. O. Address. St. Clair, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.