

Registration District No. 47

Primary Registration District No. 3008

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

1. PLACE OF DEATH

(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution State Hosp #1 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3m 29
(Specify whether
In this community same
years, months or days)

3. (a) PRINT FULL NAME MAGGIE COX

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

4. Sex ♀ 3 5. Color or race col
6. (b) Name of husband or wife dk 6. (a) Single, widowed, married, divorced W 2
6. (c) Age of husband or wife if alive dk years
7. Birth date of deceased Jan 16 1885
(Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days 14
If less than one day _____ hr. _____ min.

9. Birthplace Frankford Mo 11
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER, FATHER { 12. Name South
13. Birthplace dk dk
(City, town, or county) (State or foreign country)
14. Maiden name Fannie Owens
15. Birthplace dk dk
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Fulton Mo

17. (a) Removal (b) Date thereof 10 5 48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia mo

18. (a) Signature of funeral director J.O. Roberts

(b) Address Columbia mo

19. (a) 10-5-1948 (b) Joan Morawickoff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion 64
(c) City or town Hannibal 4
(If outside city or town limits, write "RURAL")
(d) Street No. 1228 Center St 1
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30th
year 1948 hour one minute 35p M.

21. I hereby certify that I attended the deceased from 9/27/48, 19____, to 9/30/48, 19____;
that I last saw her alive on 9/30/48, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

B. pneumonia

Due to _____

Due to _____

Other conditions Paresis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 30/3

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? U

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

23. Signature Jocaldwell (M. D. or other) mo

Address Fulton mo Date signed 9/30/48

Date Filed Oct 12 1948
District File No. _____
DISTRICT NO. _____
REGISTERED _____

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.....
Licensed Embalmer No.....
P. O. Address.....

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..