

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29708**
Registrar's No. **3820**

FILED SEP 25 1948
Registration District No. **149**

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:
General Hospital No. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days
(Specify whether years, months or days)

In this community 42 yrs

3. (a) PRINT FULL NAME Zethro Rex Cox

3. (b) If veteran, name war none

3. (c) Social Security No. 294-16-4499

4. Sex male 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wanda Cox 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased February 15, 1898
(Month) (Day) (Year)

8. AGE: Years 50 Months 7 Days 1 If less than one day hr. min.

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

10. Usual occupation Pyrotechnist

11. Industry or business Vitale Fireworks Co

12. Name Jessie W. Cox

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

14. Maiden name Mrs. Pamton

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

16. (a) Informant Wanda Cox

(b) Address 1015 Summit

17. (a) Burial (b) Date thereof 9/20/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cem. Banner Springs, Kans

18. (a) Signature of funeral director State Funeral Home

(b) Address Kansas City, Kansas

19. (a) 9-18-48 (b) Shiraldine Holmes
(Date received local registrar) (Registrar's signature)

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. 1015 Summit
(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 16
year 1948 hour 7 minute 5 A. M.

21. I hereby certify that I attended the deceased from Sept. 9 19 48 to Sept. 16 19 48
that I last saw him alive on Sept. 16 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism
Due to due to acute heart disease (m.m.d.)

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations 95C
Of autopsy None

Duration _____
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 _____

(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 Wanda Cox (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 9-16-48

for [unclear]

SEP 10 1940

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..... *Wm. L. Ward*

Licensed Embalmer No. *3991*

P. O. Address. *308 East 68th Street*

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.