

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

BIRTH NO.		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>60</u>	
1. PLACE OF DEATH a. COUNTY <u>Howell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Arkansas</u> b. COUNTY <u>Fulton</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>		c. LENGTH OF STAY (In this place) <u>6 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MAMMOTH SPRING 8030</u>		d. STREET ADDRESS (If rural, give location) <u>SP 1008</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Christi Haged Hospital</u>				3. NAME OF DECEASED a. (First) <u>Chesley</u> b. (Middle) <u>Harrison</u> c. (Last) <u>Cozont</u>			
4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 9 1950</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married 1</u>	
8. DATE OF BIRTH <u>Sept. 21 1875 75</u>		9. AGE (In years last birthday) <u>75</u>		IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 6 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>James Cozont</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Flosie Cozont</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Oliver Cozont married son</u> ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/4</u> , 19 <u>50</u> to <u>11/9</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>11/9</u> , 19 <u>50</u> , and that death occurred at <u>11:15 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M. D.</u>				23b. ADDRESS <u>West Plains, Missouri</u>		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11-11-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Monriston</u>		24d. LOCATION (City, town, or county) (State) <u>Fulton, Ark.</u>	
DATE REC'D BY LOCAL REG. <u>11-15-50</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> <u>379</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>[Address]</u>			

DIVISION OF HEALTH OF MO.  
District No. 5 - Springfield

RECEIVED NOV 20 1950

Dist. File 1150-2330

Date Filed 11/29/50

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....  
Student Embalmer

Signed

*J. H. Best*

Licensed Embalmer No. 659

P. O. Address Embroidery, Arkansas

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.