

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

40358

FILED DEC 8-1951

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>322</u>		PRIMARY REG. DIST. NO. <u>3071</u>		Registrar's No. <u>50</u>	
1. PLACE OF DEATH a. COUNTY <u>Saline</u> <u>0971</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u>		c. LENGTH OF STAY (In this place) <u>60 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Slater</u> <u>0971</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>none</u>				d. STREET ADDRESS (If rural, give location) <u>233 E. Emma</u> <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u>			b. (Middle) <u>Percell</u>		c. (Last) <u>Fox</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 30-1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Mch. 1st 1870</u>		9. AGE (In years last birthday) <u>72</u>	if UNDER 1 YEAR Months <u>8</u> Days <u>29</u>	if UNDER 24 HRS. Hours <u></u> Min. <u></u>
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 <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Malta Bend, Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13a. FATHER'S NAME <u>Wm. O. Fox</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Wilson</u>		14. NAME OF HUSBAND OR WIFE <u>Rosa Fox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. W. P. Fox Slater-Mo.</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriothrombosis left leg with gangrene and</u> DUE TO (b) <u>tension & uremia.</u> DUE TO (c) <u>Had an arteriothrombosis in rt. leg. Oct 18, 1951.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>in rt. leg. Oct 18, 1951.</u>				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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>454x</u>			
22. I hereby certify that I attended the deceased from <u>Oct. 14, 1951</u> , to <u>Nov. 30, 1951</u> , that I last saw the deceased alive on <u>Nov. 30, 1951</u> , and that death occurred at <u>3:15 P. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>O. A. McBurney M.D.</u>				23b. ADDRESS <u>Slater, Mo.</u>		23c. DATE SIGNED <u>12/8/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>12/2/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Slater, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>12/3/51</u>		REGISTRAR'S SIGNATURE <u>Mrs. Earl Comely</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Brothers</u>		ADDRESS	

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

RECEIVED DEC 7 1951

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed DEC 7 1951

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Sam M Hill

Licensed Embalmer No. 1292

P. O. Address Slater Mo

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.