

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32144

1952 OCT 9

BIRTH NO. _____ REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 5644 Registrar's No. 95

1. PLACE OF DEATH a. COUNTY LAFAYETTE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY LAFAYETTE	
b. CITY OR TOWN RURAL LESINGTON TWP		c. CITY OR TOWN CARROLL MO	
c. LENGTH OF STAY (in this place) 2 1/2 YRS		d. STREET ADDRESS 3 1/2 mi. off Highway	
d. FULL NAME OF HOSPITAL OR INSTITUTION LAFAYETTE COUNTY HOME		e. (If rural, give location)	

3. NAME OF DECEASED (Type or Print) CHARLES	a. (First)	b. (Middle) LEE	c. (Last) COX	4. DATE OF DEATH (Month) / (Day) / (Year) SEPTEMBER 25 1952
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH NOV 17 1866	9. AGE (In years) 85	MONTHS 10	YEARS 8	IF UNDER 18: Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER DAY	10b. KIND OF BUSINESS OR INDUSTRY DAY LABORER	11. BIRTHPLACE (State or foreign country) LAFAYETTE COUNTY MO	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Louis W. Cox	13b. MOTHER'S MAIDEN NAME ELIZABETH FLETCHER	14. NAME OF HUSBAND OR WIFE NONE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. NA	17. INFORMANT'S SIGNATURE OR NAME B. F. COX	ADDRESS ROCK FORT MO
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH Years -
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Benign Hypertrophy of Prostate 4200	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from March 1, 1950, to Sept 25, 1952, that I last saw the deceased alive on Sept 22, 1952 and that death occurred at 5:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE W. Koppensind M.D. (Degree or title)	23b. ADDRESS Higginsville, Mo.	23c. DATE SIGNED Sept 27 52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 9/27/52	24c. NAME OF CEMETERY OR CREMATORY DOVER CEMETERY	24d. LOCATION (City, town, or county) (State) DOVER MO
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DATE REC'D BY LOCAL REG. 10-6-52	REGISTRAR'S SIGNATURE Thelma Eustace	158-C	25. FUNERAL DIRECTOR'S SIGNATURE G. J. James	ADDRESS Concordia Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed E. S. James

Licensed Embalmer No. 205-8

P. O. Address Concordia 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.