

BIRTH NO. _____ REG. DIST. NO. **282** PRIMARY REG. DIST. NO. **3055** Registrar's No. **78**

2841

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

1. PLACE OF DEATH a. COUNTY Home, Polk, Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Polk	
b. CITY (If outside corporate limits, write RURAL and give township) Bolivar, mo		c. CITY (If outside corporate limits, write RURAL and give township) Bolivar 0841	
c. LENGTH OF STAY (in this place) 1 1/2 years		d. STREET ADDRESS (If rural, give location) Corner of Reed + Chestnut	
d. FULL NAME OF HOSPITAL OR INSTITUTION Corner of Reed + Chestnut		e. (If rural, give location) Corner of Reed + Chestnut St	

3. NAME OF DECEASED (Type or Print) a. (First) SAMUEL b. (Middle) GRANT c. (Last) COX			4. DATE OF DEATH (Month) (Day) (Year) June 23-53
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec. 13, 1862	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months 6 Days 10	IF UNDER 12 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (City and State or Foreign Country) Polk, Co Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Sullivan Cox	13b. MOTHER'S MAIDEN NAME Smith Wright	14. NAME OF HUSBAND OR WIFE Mrs. Julia Cox
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no.	16. SOCIAL SECURITY NO. no.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Julia Cox	ADDRESS Bolivar, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute heart failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Chronic myocarditis		
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 4222	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)	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 **June 1, 1953** to **June 23, 1953**, that I last saw the deceased alive on **June 21, 1953**, and that death occurred at **2:00A m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. M. Green M.D.	23b. ADDRESS Bolivar Mo	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE June 28, 53	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) Bolivar mo
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DATE REC'D BY LOCAL REG. June 26, 1953	REGISTRAR'S SIGNATURE Ralph Gordon	25. FUNERAL DIRECTOR'S SIGNATURE Blue Bolivar	ADDRESS mo
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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

Chy Kuster

Licensed Embalmer No. 4154

P. O. Address Bethesda, Md.

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.