

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23320**

FILED AUG 8 - 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **308d** Registrar's No. **164**

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Charles</b>	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Charles</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>424 S. Main St.</b>		e. STREET ADDRESS (If rural, give location) <b>424 S. Main St.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>THOMAS</b>	b. (Middle) <b>L</b>	c. (Last) <b>COX</b>	4. DATE OF DEATH (Month) (Day) (Year)	<b>July 31, 1955</b>
-------------------------------------	--------------------------	----------------------	----------------------	---------------------------------------	----------------------

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 17, 1881</b>	9. AGE (In years last birthday) <b>74</b>	# UNDER 1 YEAR <b>6</b> Months	# UNDER 24 HRS. <b>14</b> Days
--------------------	-------------------------------	---	---------------------------------------	---	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>American Car Co.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Lincoln Co., Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>
--	---	---	---

13a. FATHER'S NAME <b>Thomas H. Cox</b>	13b. MOTHER'S MAIDEN NAME <b>Rebecca Barns</b>	14. NAME OF HUSBAND OR WIFE <b>Nola Hawkins Cox</b>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>498-01-0353</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Nola Cox, St. Charles, Mo.</b>	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		INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>3 yrs</b> <b>5 yrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Heart Failure</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Gen arterio sclerosis</b> DUE TO (c) <b>4500,</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>osteoarthritis Back</b>			

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) m.	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 **3-27-55**, to **7-31-55**, that I last saw the deceased alive on **7-30-55**, and that death occurred at **11 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>R. K. Little M.D.</b> (Degree or title)	23b. ADDRESS <b>St. Charles, Mo</b>	23c. DATE SIGNED <b>August 2, 1955</b>
---	-------------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Aug. 2, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Charles, Missouri</b>
---	-------------------------------	--	--

DATE REC'D BY LOCAL REG. <b>Aug 2 1955</b>	REGISTRAR'S SIGNATURE <b>Frankie H. ...</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur C. Bone, St. Charles, Mo.</b>	ADDRESS
--	---	--	---------

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 ....., Student Embalmer No.....

working under my personal supervision.

Student.....  
Signature of Student Embalmer

Signed *Plarue M. Bill*.....

Licensed Embalmer No. *437*.....

P. O. Address *St. Charles*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.