No. 300
10.48

FILED APR 18 1956

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 13198

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO 1002 Registrar's No. 1411

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

**1. PLACE OF DEATH**
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (in this place): 6 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital #1

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
d. Is Residence within limits of a city or incorporated town? Yes [X] No [ ]
e. STREET ADDRESS (If rural, give location): 2528 Washington

**3. NAME OF DECEASED** (Type or Print)
a. (First): ELMON
b. (Middle): THOMAS
c. (Last): COX

**4. DATE OF DEATH** (Month) (Day) (Year): March 31 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan 6, ~~1912~~ 1913
9. AGE (In years last birthday): ~~42~~ 43 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Highway Trailer
11. BIRTHPLACE (City and State or Foreign Country): Kingsland Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME: Thaudous E Cox
13b. MOTHER'S MAIDEN NAME: Addie Mae Crain
14. NAME OF HUSBAND OR WIFE: Mary Magdaline Cox

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.: 429-09-8449
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Mary M Cox 2528 Washington K.C. Mo

**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, asthenia, etc. It means the disease, injury, or complication which caused death.

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Rib Fracture

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Hemothorac Ruptured Spleen

DUE TO (c) + L Kidney Hemofectoneme

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

845X
46

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Farm
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Jackson Co
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 3-31-56-3:30 p.m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Thrown from Horse Struck Stump Tree

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Hugh H. Owens (Degree or title) Hugh H. Owens Carcner
23b. ADDRESS: 1034 Rialto Bldg
23c. DATE SIGNED: 4-2-56

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 4/2/56
24c. NAME OF CEMETERY OR CREMATORY: Kingston Cemetery
24d. LOCATION (City, town, or county) (State): Fardice Arkansas

DATE REC'D BY LOCAL REG.: 4-2-56
REGISTRAR'S SIGNATURE: Neva Minshall
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Sheil Funeral Home Kansas City Mo.

(Licensed Embalmer's Statement on Reverse Side)

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Thomas A. Sheil

Licensed Embalmer No. 495

P. O. Address K. C. M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.