

FILED JUL 17 1956

STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. 276 PRIMARY REG. DIST. NO. 4410 Registrar's No. 50

1. PLACE OF DEATH
a. COUNTY Phelps

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE MO. b. COUNTY Phelps

b. CITY (If outside corporate limits, write RURAL and give township) St. James c. LENGTH OF STAY (in this place) 2 1/2 yrs.
c. CITY OR TOWN St. James d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Soldiers Home Hospital e. STREET ADDRESS (If rural, give location) 0810

3. NAME OF DECEASED (Type or Print)
a. (First) Ruth b. (Middle) Jane c. (Last) Cox

4. DATE OF DEATH (Month) (Day) (Year)
July 7, 1956

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH Dec. 4, 1889 9. AGE (In years last birthday) 66 IF UNDER 1 YEAR 7 Months 3 Days IF UNDER 4 HRS. 1 Hour 3 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (City and State or Foreign Country) Phelps Co. MO 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Samuel Wilson 13b. MOTHER'S MAIDEN NAME Caroline Bailey 14. NAME OF HUSBAND OR WIFE Timothy 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. 493-25-9804 17. INFORMANT'S SIGNATURE OR NAME Carl Cox - (son) ADDRESS St. James, 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, asthma, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Colon
ANTECEDENT CAUSES Metastasis
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Due to (b) Indefinite
DUE TO (c) Indefinite

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 _____ 20. AUTOPSY? YES NO

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) 153X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Jan 26, 1953 to July 7, 1956, that I last saw the deceased alive on July 7, 1956, and that death occurred at 10:40 P.M., from the causes and on the date stated above.

23a. SIGNATURE Josa. Grosskreutz, M.D. (Type or Print) 23b. ADDRESS Dr. Jaura, MO 23c. DATE SIGNED 7-8-56

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE July 10-1956 24c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery 24d. LOCATION (City, town, or county) (State) St. James, MO

DATE REC'D BY LOCAL REG. 7-9-1956 REGISTRAR'S SIGNATURE Ruth B. Powell 25. FUNERAL DIRECTOR'S SIGNATURE Prof. E. Licklider ADDRESS St. James, MO

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

479-0

RECEIVED

Phelps County Health Officer,

County File Number 467

Date Filed 7/16/56

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.....
Signature of Student Embalmer

Signed Grace E. Licklider

Licensed Embalmer No. 35

P. O. Address St James

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.