

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 24 1956

28246

State File No.

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 6853

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.					
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE				b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN				c. LENGTH OF STAY (in this place) 1 week		c. CITY OR TOWN		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION				e. STREET ADDRESS (If rural, give location)				0230 /			
Missouri Baptist Hospital				Route 2							
3. NAME OF DECEASED (Type or Print)			a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)		
Igom			Cox						July 22, 1956		
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED/ WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
Male		White		Married		April 7th 1878		78			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)		12. CITIZEN OF WHAT COUNTRY?			
Retired Mail Carrier U.S. Government				Dent Co., Mo.		Dent Co., Mo.		U.S.			
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE					
Albert Cox			Martha Greenwood			Unavailable					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME			ADDRESS			
NO			None		Velma Cox, Salem, Mo.						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH			
		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerotic cardiovascular disease with hemiplegia (left)									
		ANTECEDENT CAUSES									
		* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.									
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.									
		DUE TO (b) Disease (i.e. hemiplegia (left) and cardiac arrhythmia									
		DUE TO (c) And Cardiac arrhythmia									
		11. OTHER SIGNIFICANT CONDITIONS resection volvulus, small bowel 7-15-56									
		Conditions contributing to the death but not related to the disease or condition causing death. Resection Volvulus Small Bowel 7/15/56									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY?			
7/15-15		Gangrene of Ileum - Resected & anastomosed						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)							
				422.1							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?							
7-22-56				7-22-56							
22. I hereby certify that I attended the deceased from 7-15-56, 1956, and that death occurred at 7:00 p.m., 7-22-56, from the causes and on the date stated above. 7-23-56											
23a. SIGNATURE (Degree or title)						23b. ADDRESS			23c. DATE SIGNED		
Arthur R. Dalton, M.D.						453 N. Taylor			7/23/56		
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)					
Removal		7-22-56		Cedar Grove Cemetery		Salem, Mo.					
DATE REC'D BY LOCAL REG.			REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS		
JUL 23 1956			Carl Smith			Albert H. Hoppe, 4700 Washington Blvd.					

**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 *Stanley H. Dixon*  
Licensed Embalmer No. *419*  
P. O. Address *St. L.*

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.