

Dept. Health,  
& Welfare  
S. Public  
Health Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39242

FILED DEC 16 1957

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1350

V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Joseph</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Meth. Hospital</b> Length of stay in lb <b>Lifetime</b>		d. STREET ADDRESS (If outside, give location) <b>2732 Felix Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Estill</b> Last <b>Cox</b>			4. DATE OF DEATH Month <b>December</b> Day <b>4</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 1, 1872</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Pres.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sun Mfg. Co.</b>	9. AGE (In years last birthday) <b>85</b> FUNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>St. Joseph, Missouri.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>James E. Cox</b>		13b. MOTHER'S MAIDEN NAME <b>Mary T. Harris</b>	
14. NAME OF HUSBAND OR WIFE <b>Minnie Rush Cox.</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>491-09-6362</b>		17. INFORMANT <b>Marion E. Cox</b> Address <b>St. Joseph, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Progressive pulmonary edema.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <b>Extensive posterior myocardial infarction.</b> DUE TO (c) <b>Arteriosclerotic heart disease w/coronary sclerosis.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b> <b>9 days</b> <b>s. yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes melitus 25 yrs; first degree AV heart block many yrs. duration</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Feb. 2, 1956</b> to <b>Dec. 4, 1957</b> and last saw <sup>her</sup> him alive on <b>12/4/57</b> Death occurred at <b>2:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Carroll Potter, Jr. M.D.</i> (Degree title)		22b. ADDRESS <b>Phy. &amp; Surg. Bldg. St. Joseph, Mo.</b>	
22c. DATE SIGNED <b>12/9/57</b>		23a. BURIAL, CREATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>Dec. 6, 1957.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Mora Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Meierhoffer-Fleeman, Inc., St. Joseph, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>Dec. 12, 1957</b>		26. REGISTRAR'S SIGNATURE <i>Mrs. Robert Fulton</i>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Edward R. Harrington* .....

Licensed Embalmer No. 3258 .....

P. O. Address St. Joseph, Mo. ....

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.