

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-021256  
STATE FILE NUMBER

FILED JUL 1 1958 Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 69

1. PLACE OF DEATH a. COUNTY <i>Clay</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo 6001</i> b. COUNTY <i>Clay</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>No. Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>No. Kansas City</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>809 E. 21 Ave</i>		Length of stay in 1b <i>18 yrs.</i>	d. STREET ADDRESS (If outside, give location) <i>809 E. 21 Ave</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>LELAND G. COX</i>			4. DATE OF DEATH Month Day Year <i>6-20-1958</i>		
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-4-1893</i>	9. AGE (In years) Last birthday <i>73</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Barber</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>Buffalo Kansas</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
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13a. FATHER'S NAME <i>William Cox</i>	13b. MOTHER'S MAIDEN NAME <i>Bell Star</i>	14. NAME OF HUSBAND OR WIFE <i>Gladys Cox</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Yes U. S. #1</i>	16. SOCIAL SECURITY NO. <i>509-16-3608</i>	17. INFORMANT Address <i>Mrs. Gladys Cox - 809 E. 21 Ave</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Hyper-tensive Cardio-Vascular disease</i>	
	DUE TO (c) <i>443X</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 p.m.	

20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from *6-14-58* to *6-20-58* and last saw him alive on *6-20-58*  
Death occurred at *11:30 A.M.* on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Edward J. Formich MD</i> (Degree or title)	22b. ADDRESS <i>4030 N. Oak KC 16 Mo</i>	22c. DATE SIGNED <i>6-20-58</i>
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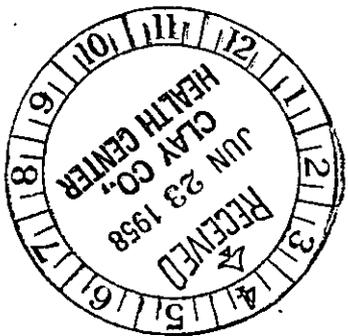
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>6-22-1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedarvale Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Neosho, Falls, Kansas</i>
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24. FUNERAL DIRECTOR <i>D. W. Newcomer's Sons N.K.C. Mo</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>6-21-58</i>	26. REGISTRAR'S SIGNATURE <i>Marguerite Hudgens</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

OCT 27 1958



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 *Glenn A. Hill* .....

Licensed Embalmer No. *4586*

P. O. Address *K.C. 16. 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.