

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000444

STATE FILE NUMBER

FILED FEB 2 1959

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 29

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Moniteau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Latham</u> 680
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hosp. #1</u>		Length of stay in lb <u>7 days</u>	d. STREET ADDRESS <u>Unknown</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Asberry Monroe Cox</u>			4. DATE OF DEATH Month Day Year <u>Jan. 23 1959</u>		
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5. SEX <u>Male</u> 0	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1875</u>	9. AGE (In years last birthday) <u>83</u>	FUNDER 1 YEAR Months Days	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) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Johnson</u>	14. NAME OF HUSBAND OR WIFE <u>-----</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, state service) <u>Unknown</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>State Hospital #1</u> Address <u>Fulton, Mo.</u>
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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) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic Brain Syndrome</u>	
	DUE TO (c) _____	
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"/> 0

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.) <u>309x</u>
20c. TIME OF INJURY Hour Month, Day, Year g.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
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21. I attended the deceased from Jan. 16, 1959 to Jan. 23, 1959 and last saw ^{her}him alive on _____
Death occurred at 9:55 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Dr. J. Freund M.D.</u> (Degree or title)	22b. ADDRESS <u>State Hospital #1, Fulton, Mo</u>	22c. DATE SIGNED <u>1, 23, 1959</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-25-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HIGHLAND CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>LATHAM MO.</u>
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24. FUNERAL DIRECTOR <u>MAUPIN FUNERAL HOME</u> ADDRESS <u>FULTON MO.</u>	25. DATE RECD. BY LOCAL REG. <u>Jan 28 - 1959</u>	26. REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

FEB 3 1959

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 Marshall L. Blackwell

Licensed Embalmer No. 4713
P. O. Address Fullon, 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.