

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012667

STATE FILE NUMBER  
Registrar's No. 2048

Registration District No. 393 Primary Registration District No. 1002

**FILED MAY 13 1959**

1. PLACE OF DEATH a. COUNTY <b>Clay Co.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>Caldwell</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City, North</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kingston</b> <b>0130</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4417E 46TH N. UNK.</b>		Length of stay in 1b <b>unk.</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Cox</b> Last <b>Cox</b>			4. DATE OF DEATH <b>April 23, 1959</b> Month <b>April</b> Day <b>23</b> Year <b>1959</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-21-1881</b>
9. AGE (In years last birthday) <b>78 77</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b>	IF UNDER 24 HRS Hours <b>7</b> Min. <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	11. BIRTHPLACE (City and state or country) <b>Caldwell County, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>Samuel Cox</b>	
13b. MOTHER'S MAIDEN NAME <b>Nellie Gildersleeve</b>		14. NAME OF HUSBAND OR WIFE <b>Jane 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>-</b>	17. INFORMANT Address <b>Mrs. Jane Cox Kingston, 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>right sided heart failure</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerotic heart disease</b>			<b>indefinite</b>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>			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 _____ 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>April 16 1959</b> to <b>April 23-59</b> and last saw her alive on <b>April 22, 1959</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>F. A. Pileggi M.D.</b>		22b. ADDRESS <b>1806 Swift N. K. C. 16, Mo.</b>	22c. DATE SIGNED <b>4-23-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>4-26-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Kingston Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kingston, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Cramer Clark Kingston, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>4-24-59</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall.</b>

F. A. Pileggi USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No.....

P. O. Address .....

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.