

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017446

STATE FILE NUMBER

FILED JUN 8 1959

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 96

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-57

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Grundy</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Tranton</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Child</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cullen Hospital</u> | | Length of stay in 1b <u>2 Weeks</u> | d. STREET ADDRESS (If outside, give location) <u>6590 6mi NE Child</u> |
| 3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>Milton</u> Last <u>Cox</u> | | | 4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>1959</u> |
| 5. SEX <u>Male</u> | 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>January 20 1879</u> |
| 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> | 9. AGE (In years last birthday) <u>80</u> |
| 11. BIRTHPLACE (City and state or country) <u>Menifee Co. Ky.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>James Callaway Cox</u> | | 13b. MOTHER'S MAIDEN NAME <u>Phoebe Jane Gore</u> | 14. NAME OF HUSBAND OR WIFE <u>Myrtle Cox</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>487-42-6827</u> | 17. INFORMANT <u>Myrtle L Cox</u> Address <u>Child 9th</u> |
| 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>Cerebral Hemorrhage</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis &</u> | | | |
| DUE TO (c) <u>Chronic Arteritis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331X</u> | | | |
| 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 _____ a.m. _____ p.m. Month, Day, Year _____ | | | |
| 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 | |
| 21. I attended the deceased from <u>May 11 59</u> to <u>May 23 59</u> and last saw ^{her} him <u>alive on May 23 59</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>E. J. Robertson MD</u> (Degree or title) | | 22b. ADDRESS <u>Tranton Mo</u> | |
| | | 22c. DATE SIGNED <u>5/26/59</u> | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>5/27/59</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Alpha Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Laredo MO</u> | |
| 24. FUNERAL DIRECTOR <u>E. J. Robertson Funeral Home</u> ADDRESS <u>Laredo</u> | | 25. DATE RECD. BY LOCAL REG. <u>5/27/59</u> | |
| | | 26. REGISTRAR'S SIGNATURE <u>Irene Fair</u> | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *J. M. Robertson*

Licensed Embalmer No. *4388*

P. O. Address *Lareels*

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.