

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 7 1961

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STATE FILE NUMBER

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 17

AMENDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Ray</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Twp. J.W.S.P.</b>		Length of stay in lb <b>2 days</b>		c. CITY OR TOWN <b>Richmond</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Ray County Memorial Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>204 Forest</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eunice Cox</b>				4. DATE OF DEATH Month Day Year <b>January 29, 1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-27-1901</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>S.W. Bell Tele. Company</b>		11. BIRTHPLACE (City and state or country) <b>Anthony Kansas</b>		12. CITIZEN OF WHAT COUNTRY <b>United States</b>	
13a. FATHER'S NAME <b>James W. Swafford</b>		13b. MOTHER'S MAIDEN NAME <b>Mamma Dean Seth</b>		14. NAME OF HUSBAND OR WIFE <b>Robert Cox (des)</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>496-07-2323</b>		17. INFORMANT Address <b>Mrs. Dinelia Dean Riggs, Orrick, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b>						<b>24 hrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Peptic ulcer.</b>						<b>2 weeks.</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)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <b>July 1, 1960</b> to <b>Jan 29-61</b> and last saw her/him alive on <b>Jan 29-61</b> Death occurred at <b>5:00 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Charles T. Pledge M.D.</b>				22b. ADDRESS <b>Richmond MO</b>		22c. DATE SIGNED <b>Jan 30 61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-1-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunny Slope</b>		23d. LOCATION (City, town, or county) (State) <b>Richmond, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Quest Life Funeral Home Richmond, Missouri</b>				25. DATE RECD. BY LOCAL REG. <b>2-4-1961</b>		26. REGISTRAR'S SIGNATURE <b>Malcol Jackson</b>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

FEB 8 1961

**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 *George D. Pile*

Licensed Embalmer No. 4066

P. O. Address Beltsville, Md.

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.