

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-038647 ✓

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5131 STATE FILE NUMBER

FILED OCT 25 1962

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Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in lb <u>26 days</u>	c. CITY OR TOWN <u>INDEPENDENCE</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>V A HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1530 RALSTON</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK LESTER COX</u>		4. DATE OF DEATH Month Day Year <u>October 9, 1962</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>7-28-86</u>
9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Carthage, Illinois</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Henry F. Cox</u>	
13b. MOTHER'S MAIDEN NAME <u>Nancy Ann Kimbrough</u>		14. NAME OF HUSBAND OR WIFE <u>Dorcas Cox</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT Address <u>VA Hospital Official Records, K.C. Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Occlusion of right coronary artery</u> DUE TO (b) <u>Thrombosis superimposed on atheroma</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Emphysema; atelectasis of left lower lobe of lung</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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>September 13, 1962</u> to <u>October 9, 1962</u> Death occurred at <u>7:55a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M. A. Mac Autay</u> (Designate title)		22b. ADDRESS <u>VA Hospital, Kansas City, Mo.</u>	22c. DATE SIGNED <u>10-9-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>10-10-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOSS RIDGE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CARTHAGE, ILLINOIS</u>
24. FUNERAL DIRECTOR ADDRESS <u>GEO. C. CARSON & SONS, INDEPENDENCE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>10-10-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

STATE OF

NEW YORK

DEPARTMENT OF

HEALTH

AND

WELFARE

OFFICE OF

EMBALMERS

STATE OF NEW YORK

NO. 1

OF

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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. T. Crowell*
Licensed Embalmer No. 4904

P. O. Address: H. C. No.

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.

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