

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-046520
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1937 62-046520

FILED JAN 14 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 20 YRS.	c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HANDLEY MEMORIAL HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2816 W. WATER Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT C. COX			4. DATE OF DEATH Month Day Year DEC. 31, 1962
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/23/98
9. AGE (last birthday) 64		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FROM STATE		10b. KIND OF BUSINESS OR INDUSTRY HIGHWAY DEPT.	11. BIRTHPLACE (City and state or country) MISSOURI
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME JOHN COX	
13b. MOTHER'S MAIDEN NAME ELLEN JOHNSON		14. NAME OF HUSBAND OR WIFE OLIVE COX	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT MRS. OLIVE COX / 2816 W. WATER Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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 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 _____ to _____ and last saw ^{him} live on _____ Death occurred at <u>3:00</u> <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Edith B. H. Doolittle, M.D.</i>		22b. ADDRESS SPRINGFIELD, MISSOURI	22c. DATE SIGNED 1/2/63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1/2/63	23c. NAME OF CEMETERY OR CREMATORY EISENHOWER CEMETERY	23d. LOCATION (City, town, or county) REEDS SPRING, MISSOURI
24. FUNERAL DIRECTOR AYRE-GOODWIN	ADDRESS SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 1-9-63	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>

JAN 23 1963
FEB 8 1963

Permit
Dec 31 19

STATEMENT BY LICENSED EMBALMER

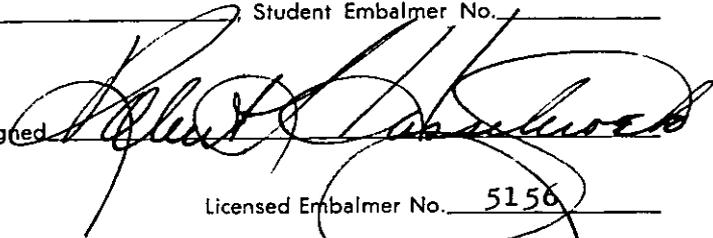
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 5156

P. O. Address Springfield, 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.