

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

3-039844

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5563 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

H. OWENS MEDICAL CERTIFICATION

HUBBARD

USE BLACK INK OR TYPEWRITER RIBBON

FILED OCT 24 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>JACKSON</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in lb <u>70 Yrs</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>916 Forest</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE - (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u></p> <p>c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>916 Forest</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM R. Cox</u></p> <p>4. DATE OF DEATH Month Day Year <u>October 11 1963</u></p>	<p>5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>6-23-1892</u> 9. AGE (last birthday) <u>71</u></p> <p>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>Farming</u> 11. BIRTHPLACE (City and state or country) <u>unknown Illinois</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>
<p>13a. FATHER'S NAME <u>unknown Cox</u> 13b. MOTHER'S MAIDEN NAME <u>Julie Amos</u></p> <p>14. NAME OF HUSBAND OR WIFE <u>Annie Cox - Dec.</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u></p> <p>17. INFORMANT <u>Mrs. Albert Burriss K.C. Mo.</u> Address <u>Dec.</u></p>	<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p>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</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p> <p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>	<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p> <p>21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.</p>
<p>22a. SIGNATURE (Degree or title) <u>Hubbard Owens Coroner</u></p> <p>22b. ADDRESS <u>152 Union Station</u></p> <p>22c. DATE SIGNED <u>10/26/63</u></p>	<p>23a. BURIAL PERMITTED? <input type="checkbox"/> REMOVAL (Specify) <u>Burial</u></p> <p>23b. DATE <u>10-14-1963</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington Cem.</u></p> <p>23d. LOCATION (City, town, or county) <u>Kansas City Mo.</u></p>
<p>24. FUNERAL DIRECTOR <u>CHURCH-ARCHER Co. Liberty, Mo.</u></p>	<p>25. DATE RECD. BY LOCAL REG. <u>10-14-63</u></p> <p>26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u></p>

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 Harold G. Smith

Licensed Embalmer No. 4575

P. O. Address Liberty, 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.