

1 PLACE OF DEATH
STATE OF TEXAS

TEXAS STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

47005 62
Registrar's No.

COUNTY OF *Tom Green*

PRECINCT NO. *1* No. *1* Street *St Johns Hospital*
If in an Institution, give name of Institution instead of Street and No.

Length of residence in city where death occurred yrs. mos. *1* days. How long in U. S. if foreign born? yrs. mos. days.

2 FULL NAME OF DECEASED *Leslie Warren Cox* *Stephenville, Tex.*
Residence: No. Street. If non-residence give city, or town and state

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. Single Married Widowed Divorced <i>married</i> (Write the word)
5a. If married, widowed, or divorced HUSBAND of <i>Mrs Pauline Cox</i> (or) WIFE of		
6. DATE OF BIRTH (month, day, and year) <i>Aug 14 - 1905</i>		
7. AGE <i>29</i> Years <i>2</i> Months <i>0</i> Days	If LESS than 1 day, hrs. or min.	
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>School Teacher</i>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) *Oct 14 1934*

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

I last saw h..... alive on 19.....; death is said to have occurred on the date stated above, at *10:30 a.m.*
The principal cause of death and related causes of importance were as follows: *Appendicitis*

Date of onset

Other contributory causes of importance: *General Peritonitis*

12. BIRTHPLACE (city or town) (State or country) *Texas*

13. NAME *John T Cox*

14. BIRTHPLACE (city or town) (State or country) *unknown*

15. MAIDEN NAME *unknown*

16. BIRTHPLACE (City or town) (State or county) *unknown*

17. INFORMANT *Mrs Leslie W. Cox*
(Address) *Blackwell Tex*

18. BURIAL, CREMATION, OR REMOVAL Place *Stephenville Tex* Date *.....* 19.....

19. UNDERTAKER *Johnson's Funeral Parlor*
(Address) *San Angelo Tex*

20. FILE DATE AND SIGNATURE OF REGISTRAR *10-19 1934 H.C. Daniel*

Name of operation *Appendectomy* date of *Oct 14, 1934*

What test confirmed diagnosis? *Lab* Was there an autopsy? *no*

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide?

Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify

(Signed) *Aubrey L. Lewis* M. D.

(Address) *San Angelo, Texas*