

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

447

FEB 20 1935

1. PLACE OF DEATH

County Carroll
Township Leasure
City (No. _____) _____ St. _____ Ward _____

Registration District No. 133
Primary Registration District No. 5185

File No. 1
Registered No. _____

2. FULL NAME

Gemina Fuller Mosborger

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) unmarried

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas Mosborger

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 22-1856

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>79</u>	<u>4</u>	<u>3</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housekeeper
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

13. NAME J. S. Hargord

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

15. MAIDEN NAME C. Fuller

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Mrs. Carr Pitts, Cheltenham Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Interred DATE Jan 26 '35

19. UNDERTAKER (ADDRESS) Carroll Mortuary, Leasure Mo

20. FILED 1-26-1935 Garnie Henderson, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 25, 1935

22. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1935, to Jan 20, 1935.
I last saw her alive on Jan 20, 1935. Death is said to have occurred on the date stated above, at 10 9 a.m.
The principal cause of death and related causes of importance were as follows:

Cerebral Apoplexy
Date of onset Jan 5-35
Other contributory causes of importance: Senility of

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ 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) G. M. [Signature], M. D.
(Address) Leasure Mo

