

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.

5555

1. PLACE OF DEATH **MAR 20 1935**

399

County Jackson
Township Acme
City Hanson City (No. 700 Newton Ave.)

Registration District No.
Primary Registration District No. 1002

File No.
Registered No.
St. Ward)

2. FULL NAME Samuel J. Moffitt

(a) Residence, No. 700 Newton Ave. St., Ward.

(If nonresident, give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/23/1935

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William G. Moffitt

22. I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1935 to Feb. 22, 1935

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 5, 1876

I last saw her alive on Feb 22, 1935 Death is said

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
59 1 18

to have occurred on the date stated above, at 7:30 m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spliner, sawyer, bookkeeper, etc. Housewife

Cerebral Hemorrhage Date of onset 2-16-35

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

Other contributory causes of importance:
Arterio Sclerosis
Chronic myocarditis 46 5 yrs

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

13. NAME Henry Van Beber

Name of operation none Date of
What test confirmed diagnosis clinical Was there an autopsy? no

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

15. MAIDEN NAME Elizabeth Hutchins

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)

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

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

17. INFORMANT William G. Moffitt (ADDRESS) 700 Newton

Manner of injury
Nature of injury

18. BURIAL, CREMATION, OR REMOVAL PLACE Springville Mo. DATE 2-24-35

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify

19. UNDERTAKER Sheil Funeral Home (ADDRESS) 666 Indep. Ave.

(Signed) M. Cluney, M. D.
(Address) 6520 Indep. Ave

20. FILED 2/23 1935 mm Registrar.

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