

29004

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

REC'D SEP 20 1939

Registration District No. 247

Primary Registration District No. 5342

Registrar's No. 16

1. PLACE OF DEATH:

(a) County Dallas Co. Missouri

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Washington St
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

8. (a) PRINT FULL NAME THOMAS JEFFERSON MORELAND

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: June 24 1853
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>86</u>	<u>1</u>	<u>7</u>	hr. _____ min.

9. Birthplace Dallas Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business 9

MOTHER FATHER

12. Name Unknown

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature _____

(b) Address _____

17. (a) Rural (b) Date thereof Aug 1 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Mountain

18. (a) Signature of funeral director J. B. Jones

(b) Address Beulah, Missouri

19. (a) 9-8-39 (b) J. H. Hallock
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1939 hour 10:00 AM minute _____ M.

21. I hereby certify that I attended the deceased from 7-25, 1939, to 7-31, 1939
that I last saw him alive on 7-30, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Stomach

Due to _____

Due to fb

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____
(Specify type of place) (e) Means of injury

23. Signature J. H. Lindsay (M. D. or other) _____
Address Conway Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

50M-5-17-39
 Rev. 5-17-39
 U.S. GPO: 1935

RECEIVED
District Health Officer No. 7.
District File Number 7-39-1317
Date Filed 9-12-89

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 _____
_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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 this body is not embalmed, above space should be left blank.