

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.

39  
3  
6

1939 OCT 12

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

Dr. Ferrell

32415  
Do not use this space.

710

1. PLACE OF DEATH

(a) County..... GREENE ..... 2 Registration District No. .... 316

(b) Township..... SPRINGFIELD ..... 1 Primary Registration District No. .... 2001

(c) City..... (d) Street No. .... 420 W. State ..... St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME 130 Mrs. Emma Conway Moffitt

(a) Residence, No. .... 420 W. State ..... St.

(Usual place of abode, if no street address, write county or city) (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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John C. Moffitt

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 12, 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hra. or .....min.

74 1 6

OCCUPATION

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

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN)..... Henry County ..... /  
(STATE OR COUNTRY) Tenn.

FATHER

13. NAME John Wesley Guinn ..... /

14. BIRTHPLACE (CITY OR TOWN)..... South Carolina ..... /  
(STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Sarah E. Petri

16. BIRTHPLACE (CITY OR TOWN)..... South Carolina ..... /  
(STATE OR COUNTRY)

17. INFORMANT John C. Moffitt  
(ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Maple Park DATE Sept. 20, 1939

19. FUNERAL DIRECTOR (NAME) H. H. Lohmeyer  
(ADDRESS) Springfield, Mo.

20. FILE Sept 19, 1939 Chas A. George  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 18, 1939

22. I HEREBY CERTIFY, That I attended deceased from 9-6, 1939, to 9-18, 1939

I last saw her alive on 9-17, 1939. Death is said to have occurred on the date stated above, at 4 a.m.

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

Cerebral apoplexy  
Senescent arteriosclerosis

Date of onset

Other contributory causes of importance:

Name of operation examination Date of

What test confirmed diagnosis examination 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) D. Ferrell, M. D.  
(Address) Springfield, Mo.

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**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.**

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