

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

33301
Do not use this space.

OCT 18 1939

1. PLACE OF DEATH

(a) County Ralls Registration District No. _____
 (b) Township Jasper, Center Primary Registration District No. _____ Registered No. _____
 (c) City _____ (d) Street No. _____ 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

Elvina Demoss Jones Mosley
 (a) Residence, No. New London St. (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) widow

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
about 85

OCCUPATION 8. Trade, profession, or particular kind of work done, as lawyer, bookkeeper, etc. at home
 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) (STATE OR COUNTRY) dont know

FATHER 13. NAME Mosley
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Elvina De Moss
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Barkley Cemetery DATE 9-10 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Schwartz - Jones
Ray W. Schwartz, Near Linton, Mo.

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept-8 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug. 16 1939 to Sept. 8 1939
 I last saw her alive on Aug. 16 1939. Death is said to have occurred on the date stated above, at _____ m.

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

Myocarditis Date of onset 8/16/39
Unknown

Name of operation _____ Date of _____
 What test confirmed diagnosis? None 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) E. H. Brooks, M. D. O.
 _____ (Address) Center, Mo.

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.

RECEIVED

District Health Officer No. 10

District File Number 10-39-1754

Date Filed OCT 9 1949

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.....

Cecil E. Schwartz
working under my personal supervision.

Registered Apprentice No. 2338

Signed Cecil E. Schwartz

Licensed Embalmer No. 2338

P. O. Address Hannibal, Mo

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

33301
Do not use this space.

1. PLACE OF DEATH
(a) County Balls Registration District No. 725-
(b) Township Center Primary Registration District No. 3956 Registered No. _____
(c) City _____ (d) Street No. _____ 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. ds. (1) How long in U.S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Elvina De Marco Jones Mosley
(a) Residence, No. New London St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid
- 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
apt 58
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
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) (STATE OR COUNTRY) Unknown
- FATHER 13. NAME Mosley
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
- MOTHER 15. MAIDEN NAME Elvina De Marco
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
17. INFORMANT (ADDRESS) C. P. G. [unclear] Center
18. BURIAL, CREMATION, OR REMOVAL PLACE Bertley Cem DATE 9/11 1939
19. FUNERAL DIRECTOR (ADDRESS) Schuchman & Jones New London
20. FILED 11/18 1939 G. Schuchman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-8 1939
22. I HEREBY CERTIFY, That I attended deceased from Aug 16 to Sept 8, 1939
I last saw her alive on Sept 16, 1939 Death is said to have occurred on the day stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:
myocarditis Date of onset _____
- Other contributory causes of importance: unknown
- Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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? _____
If so, specify _____
(Signed) C. H. Brooks, M. D.
(Address) Center

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

