

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  
STANDARD CERTIFICATE OF DEATH

Registration District No. 039 Primary Registration District No. 4320-57

**1. PLACE OF DEATH:**  
 (a) County Madison  
 (b) City or town Rural Township 32  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution ✓  
 (If not in hospital or institution, write street number or location) 9  
 (d) Length of stay: In hospital or institution ✓  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Margaret Ethel Mouser 261  
 8. (b) If veteran, name war - 8. (c) Social Security No. ✓

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Elmer Lee Mouser  
 6. (c) Age of husband or wife if alive 33 years  
 7. Birth date of deceased Mar 9 1904  
 (Month) (Day) (Year)

8. AGE: Years 36 Months 1 Days 8  
 If less than one day hr. min.

9. Birthplace Madison Co Mo  
 (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business 0

**MOTHER**  
 12. Name Jeff Hoyis  
 18. Birthplace Madison Co Mo  
 (City, town, or county) (State or foreign country)

**MOTHER**  
 14. Maiden name Maeg Shetty  
 15. Birthplace Bollinger Co Mo  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elmer Mouser  
 (b) Address Marguand

17. (a) Burial (b) Date thereof April 18 1940  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Farmington Burial

18. (a) Signature of funeral director R. W. Stewart  
 (b) Address Marguand Mo

19. (a) April 16-1940 (b) J. G. Langhater  
 (Date received local registrar) (Signature of registrar)  
By C. G. Langhater

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County Madison  
 (c) City or town Rural Township 32  
 (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 April day 17  
 year 1940 hour 2.00 minute 00 P. M.

21. I hereby certify that I attended the deceased from April 13  
1940, to April 17, 1940;  
 that I last saw her alive on April 15, 1940;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Lobar pneumonia  
 Due to 9 days

Due to 1

Other conditions Pregnancy 6 mos.  
 (Include pregnancy within 9 months of death)

Major findings:  
 Of operations ✓  
 Of autopsy ✓

Duration  
 9 days  
 1  
 Underline the cause to which death should be charged statistically.

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)  
 (c) Means of injury \_\_\_\_\_

23. Signature E. M. Scott (M-Dead other) NO  
 Address Marguand Mo Date signed 4-20-40

105

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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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15-443

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 539

Primary Registration District No. 5728

Registrar's No. 22

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Madison  
(b) City or town Bertram T.P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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.

3. (a) PRINT FULL NAME Margaret Ethel Mouser

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 36 Months 1 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 7 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration \_\_\_\_\_

Due to No delivery or abortion in this case.

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 10/8

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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 E. M. Scott (M. D. or other)

Address Madison Date signed \_\_\_\_\_

SUPPLEMENTAL

