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39  
K21492

Registration District No. **4**

Primary Registration District No. **3001**

Registrar's No. **119**

1. PLACE OF DEATH: **Adair**

2. USUAL RESIDENCE OF DECEASED:

(a) County **Kirksville Mo**  
(b) City or town **Kirksville Mo**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **A S O Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **3 Days**  
(Specify whether  
In this community  
years, months or days)

(a) State **Missouri** (b) County **Adair**  
(c) City or town **Kirksville Mo**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **901 E Randolph St.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Ruth Mosley 240**

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month **May** day **19**  
year **1940** hour **5** minute **:30 A** M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

21. I hereby certify that I attended the deceased from **May 15**, 19**40**, to **May 19**, 19**40**

6. (b) Name of husband or wife **Hubert Mosley** 6. (c) Age of husband or wife if alive **52** years

that I last saw him alive on **May 19**, 19**40** and that death occurred on the date and hour stated above.

7. Birth date of deceased **10 8 1888**  
(Month) (Day) (Year)

Immediate cause of death **Endocarditis**  
**Intestinal Obstruction** Duration **1 day**

8. AGE: **5** Years **7** Months **11** Days If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to **adhesions following former operation**  
Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death)  
PHYSICIAN \_\_\_\_\_

10. Usual occupation **Home**

Major findings: **Basal obstruction**  
Of operations \_\_\_\_\_  
Of autopsy **None**  
Underline the cause to which death should be charged statistically.

11. Industry or business **Domestic Home**

12. Name **George Hall**

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

14. Maiden name **Sudv Eddy**

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

16. (a) Informant **Hubert Mosley**

(b) Address **901 E Randolph St Kirksville**

17. (a) **Burial** (b) Date there **May 21, 40 MO**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Hill Memorial Park**

18. (a) Signature of funeral director **D. B. Riley**

(b) Address **Kirksville Mo**

19. (a) **May 23/40** (b) **Spencer L. Freeman**  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

3 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature **R. P. Ellis** (M. D. or other) **1**

Address **Kirksville Mo** Date signed **5/24/40**

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

91A

RECEIVED

District Health Officer No. 10

District File Number 6-40-1271

Date Filed JUN 13 1940

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 D. E. Riley

Licensed Embalmer No. 3308

P. O. Address Kirkville 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 17721

Registered District No. 4

Primary Registration District No. 3001

Registrar's No. 119

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Kirksville  
(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.....  
years, months or days)

3. (a) PRINT FULL NAME Ruth Mosley  
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..... year.....

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

8. AGE: Years 51 Months 7 Days 11 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..... (City, town, or county) (State or foreign country)

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)

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.

MEDICAL CERTIFICATION  
20. DATE OF DEATH Month 5 day 19 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 Endocarditis Duration.....  
Intestinal obstruction  
Due to.....  
Due to.....

Other condition adhesions followed  
(Include pregnancy within 3 months of death)  
ing former operations  
Major findings N M D  
Bowel Obstruction  
Of autopsy none  
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) (c) Means of injury.....

23. Signature R P Ellis (M. D. or other).....

Address Kirksville Mo Date signed.....

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

LOWERY MOORE

SUPPLEMENTAL

S-17721